STEVE SISOLAK
Governor

Deonne E. Contine
Board Chair

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
901 S. Stewart Street, Suite 1001 | Carson City, Nevada 89701
Telephone 775-684-7000 | 1-800-326-5496 | Fax 775-684-7028
www.pebp.state.nv.us

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Expires 04/01/2021

DAMON HAYCOCK
Executive Officer

MEETING NOTICE AND AGENDA

Name of Organization:	Public Employees' Benefits Program Board
Date and Time of Meeting:	July 25, 2019 9:00 a.m.
Place of Meeting:	The Legislative Building 401 South Carson Street, Room #1214 Carson City, NV 89701
Video Conferencing:	The Grant Sawyer State Office Building 555 East Washington Avenue, Room #4412 Las Vegas, NV 89101
Streaming Website:	www.pebp.state.nv.us

AGENDA

1. Open Meeting: Roll Call

2. Public Comment

   Public comment will be taken during this agenda item. No action may be taken on any matter raised under this item unless the matter is included on a future agenda as an item on which action may be taken. Persons making public comments to the Board will be taken under advisement but will not be answered during the meeting. Comments may be limited to three minutes per person at the discretion of the chairperson. Additional three minute comment periods may be allowed on individual agenda items at the discretion of the chairperson. These additional comment periods shall be limited to comments relevant to the agenda item under consideration by the Board. Persons unable to attend the meeting and persons whose comments may extend past the three minute time limit may submit their public comment in writing to PEBP Attn: Laura Landry 901 S. Stewart St, Suite 1001 Carson City NV 89701, Fax: (775) 684-7028 or llandry@peb.nv.gov at least two business days prior to the meeting. Persons making public comment need to state and spell their name for the record at the beginning of their testimony.

3. PEBP Board disclosures for applicable Board meeting agenda items. (Brandee Mooneyhan, Deputy Attorney General) (Information/Discussion)
4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

   Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

   4.1 Approval of Action Minutes from the April 29, 2019 PEBP Board Meeting.

   4.2 Approval of Action Minutes from the May 23, 2019 PEBP Board Meeting.

   4.3 Receipt of quarterly staff reports for the period ending March 31, 2019:

   4.3.1 PEBP Chief Financial Officer Reports

   4.3.1.1 Budget Report

   4.3.1.2 Utilization Report

   4.4 Receipt of quarterly vendor reports for the period ending March 31, 2019:

   4.4.1 HealthSCOPE Benefits – Obesity Care Management Program

   4.4.2 Hometown Health Providers – Utilization and Large Case Management

   4.4.3 The Standard Insurance – Basic Life and Long-Term Disability Insurance

   4.4.4 Towers Watson's One Exchange – Medicare Exchange

   4.5 Accept the Fiscal Year 2019 Other Post-Employment Benefits (OPEB) valuation prepared by Aon in conformance with the Governmental Accounting Standards Board (GASB) requirements.
5. Health Claim Auditors, Inc. quarterly audit of HealthSCOPE Benefits for the timeframe January 1, 2019 – March 31, 2019: (1) Report from Health Claim Auditors; (2) HealthSCOPE Benefits response to audit report; and (3) for possible action to accept audit report findings and assess penalties, if applicable, in accordance with the performance guarantees included in the contract pursuant to the recommendation of Health Claim Auditors. (**For Possible Action**)
6. Discussion and update on PEBP's Open Enrollment results for Plan Year 2020. (Laura Rich, Operations Officer) (Information/Discussion)
7. Discussion and possible action to approve a retroactive amendment with HealthSCOPE Benefits for lowered cost out-of-state medical network services available to members on the Consumer Driven Health Plan (CDHP) and Exclusive Provider Options (EPO) plan. (Cari Eaton, Chief Financial Officer) (**For Possible Action**)
8. Discussion, update and possible action on the 80th Legislative Session with Board approval to opt-in to emergency service reimbursement provisions of AB 469 and update plan benefits for CDHP and EPO members on January 1, 2020 in accordance with AB 472 for the addition of gestation carrier maternity services. (Damon Haycock, Executive Officer) (**For Possible Action**)

9. Election of Board Vice-Chair pursuant to Nevada Administrative Code (NAC) 287.172. Eligible candidates are Don Bailey, Sr., Linda Fox, Leah Lamborn, John Packham, Mandy Hagler, Tom Verducci, and Christine Zack. (Deonne Contine, Board Chair) (**For Possible Action**)
10. Public Comment

    Public comment will be taken during this agenda item. Comments may be limited to three minutes per person at the discretion of the chairperson. Persons making public comment need to state and spell their name for the record at the beginning of their testimony.
11. Adjournment

The supporting material to this agenda, also known as the Board Packet, is available, at no charge, on the PEBP website at www.pebp.state.nv.us/board.htm (under the Board Meeting date referenced above).
An item raised during a report or public comment may be discussed but may not be deliberated or acted upon unless it is on the agenda as an action item.
All times are approximate. The Board reserves the right to take items in a different order or to combine two or more agenda items for consideration to accomplish business in the most efficient manner. The Board may remove an item from the agenda or delay discussion relating to an item on the agenda at any time. The Board reserves the right to limit Internet broadcasting during portions of the meeting that need to be confidential or closed.
We are pleased to make reasonable efforts to assist and accommodate persons with physical disabilities who wish to attend the meeting. If special arrangements for the meeting are necessary, please notify the PEBP in writing, at 901 South Stewart Street, Suite 1001, Carson City, NV 89701, or call Laura Landry at (775) 684-7020 or (800) 326-5496, as soon as possible so that reasonable efforts can be made to accommodate the request.
Copies of both the PEBP Meeting Action Minutes and Meeting Transcripts are available for inspection, at no charge, at the PEBP Office, 901 South Stewart Street, Suite 1001, Carson City, Nevada, 89701 or on the PEBP website at www.pebp.state.nv.us. For additional information, contact Laura Landry at (775) 684-7020 or (800) 326-5496.
Notice of this meeting was posted on or before 9:00 a.m. on the third working day before the meeting at the following locations: NEVADA STATE LIBRARY & ARCHIVE, 100 N. Stewart St, Carson City; BLASDEL BUILDING, 209 East Musser Street, Carson City; PUBLIC EMPLOYEES' BENEFITS PROGRAM, 901 South Stewart Street, Suite 1001, Carson City; THE GRANT SAWYER STATE OFFICE BUILDING, 555 East Washington Avenue, Las Vegas; THE LEGISLATIVE BUILDING, 401 South Carson Street, Carson City, and on the PEBP website at www.pebp.state.nv.us, also posted to the public notice website for meetings at www.leg.state.nv.us/App/Notice and https://notice.nv.gov. In addition, the agenda was mailed to groups and individuals as requested.

1.

1. Open Meeting; Roll Call

2.

2. Public Comment

3.

3. PEBP Board disclosures for applicable Board meeting agenda items. (Brandee Mooneyhan, Deputy Attorney General)
(Information/Discussion)

4.

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

4.1. Approval of Action Minutes from the April 29, 2019 PEBP Board Meeting.

4.2. Approval of Action Minutes from the May 23, 2019 PEBP Board Meeting.

4.3. Receipt of quarterly staff reports for the period ending March 31, 2019:

4.3.1. PEBP Chief Financial Officer Reports

4.3.1.1. Budget Report

4.3.1.2. Utilization Report

4.4. Receipt of quarterly vendor reports for the period ending March 31, 2019:

4.4.1. HealthSCOPE Benefits – Obesity Care Management Program

4.4.2. Hometown Health Providers – Utilization and Large Case Management

4.4.3. The Standard Insurance – Basic Life and Long-Term Disability Insurance

4.4.4. Towers Watson's One Exchange – Medicare Exchange

4.5. Accept the Fiscal Year 2019 Other Post-Employment Benefits (OPEB) valuation prepared by Aon in conformance with the Governmental Accounting Standards Board (GASB) requirements.

4.1.

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

   Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

   4.1. Approval of Action Minutes from the April 29, 2019 PEBP Board Meeting.

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

The Richard H. Bryan Building
901 South Stewart Street, Suite 1002
Carson City, Nevada 89701

ACTION MINUTES (Subject to Board Approval)
April 29, 2019

MEMBERS PRESENT IN CARSON CITY:	Ms. Deonne Contine, Board Chair Mr. John Packham, Member
MEMBERS PRESENT VIA CALL IN:	Ms. Linda Fox, Member Ms. Mandy Hagler, Member Ms. Leah Lamborn, Member Mr. Tom Verducci, Member Ms. Christine Zack, Member
MEMBERS EXCUSED:	Mr. Don Bailey, Vice Chair
FOR THE BOARD:	Ms. Brandee Mooneyhan, Deputy Attorney General
FOR STAFF:	Mr. Damon Haycock, Executive Officer Ms. Cari Eaton, Chief Financial Officer Ms. Laura Rich, Operations Officer Ms. Laura Landry, Executive Assistant

1. Open Meeting: Roll Call
   Chair Deonne Contine opened the meeting at 1:32 p.m.

2. Public Comment

   Public Comment in Carson City:

   - Kent Ervin – Nevada Faculty Alliance
   - Priscilla Maloney - Representative of AFSCME retirees

3. PEBP Board disclosures for applicable Board meeting agenda items. (Brandee Mooneyhan, Deputy Attorney General) (Information/Discussion)

4. Discussion and possible action to allow and approve PEBP to finalize Plan Year 2020 rates and participant premiums upon final decision by the Nevada Legislature to approve employer contributions (subsidy) at PEBP's budget closing hearing. (Damon Haycock, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 4.

MOTION: Motion to accept PEBP's recommendation that PEBP is authorized to make technical adjustments to the plan year 2020 rates based on legislative decision making on PEBP's fiscal year 2020 budget.
BY: Member John Packham
SECOND: Member Mandy Hagler
VOTE: Unanimous; the motion carried.

5. Discussion and possible action to delay the start of Open Enrollment from May 1st, 2019 to May 20th, 2019 and extend the end of Open Enrollment from May 31st, 2019 to June 7th, 2019 for Plan Year 2020 (July 1, 2019 – June 30, 2020). (Damon Haycock, Executive Officer) **(For Possible Action)**

BOARD ACTION ON ITEM 5.

MOTION: Motion to revise the open enrollment this year to May 20th, 2019 to June 7 of 2019.
BY: Member Tom Verducci
SECOND: Member John Packham
VOTE: Unanimous; the motion carried.

6. Public Comment

   There was no public comment.

7. Adjournment

   Chair Contine adjourned the meeting at 1:53 p.m.

4.2.

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

   Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

   4.2. Approval of Action Minutes from the May 23, 2019 PEBP Board Meeting.

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

The Richard H. Bryan Building
901 South Stewart Street, Suite 1002
Carson City, Nevada 89701

ACTION MINUTES (Subject to Board Approval)
May 23, 2019

MEMBERS PRESENT IN CARSON CITY:	Ms. Deonne Contine, Board Chair Ms. Mandy Hagler, Member Ms. Leah Lamborn, Member Mr. John Packham, Member
MEMBERS PRESENT IN LAS VEGAS:	Ms. Linda Fox, Member Ms. Christine Zack, Member
MEMBERS EXCUSED:	Mr. Don Bailey, Vice Chair Mr. Tom Verducci, Member
FOR THE BOARD:	Ms. Brandee Mooneyhan, Deputy Attorney General
FOR STAFF:	Mr. Damon Haycock, Executive Officer Ms. Cari Eaton, Chief Financial Officer Ms. Laura Rich, Operations Officer Ms. Nancy Spinelli, Quality Control Officer Ms. Laura Landry, Executive Assistant

1. Open Meeting: Roll Call
   Chair Contine opened the meeting at 9:02 a.m.

2. Public Comment
   - There were no public comments.

3. PEBP Board disclosures for applicable Board meeting agenda items. (Brandee Mooneyhan, Deputy Attorney General) (Information/Discussion)

4. Approval of Action Minutes from the March 28, 2019 PEBP Board Meeting. (Deonne Contine, Board Chair) (**For Possible Action**)

BOARD ACTION ON ITEM 4.
MOTION: Motion to approve the minutes.
BY: Member Mandy Hagler
SECOND: Member Leah Lamborn
VOTE: Unanimous; the motion carried.

5. Health Claim Auditors, Inc. quarterly audit of HealthSCOPE Benefits for the timeframe January 1, 2019 – March 31, 2019: (1) Report from Health Claim Auditors; (2) HealthSCOPE Benefits response to audit report; and (3) for possible action to accept audit report findings and assess penalties, if applicable, in accordance with the performance guarantees included in the contract pursuant to the recommendation of Health Claim Auditors. (**For Possible Action**)

BOARD ACTION ON ITEM 5.
MOTION: Motion to move Agenda Item 5, Health Claim Auditors quarterly audit report to the July meeting.
BY: Member Leah Lamborn
SECOND: Member John Packham
VOTE: Unanimous; the motion carried.

6. Discussion and possible action to allow and approve PEBP to finalize Plan Year 2020 rates and participant premiums upon final decision by the Nevada Legislature to approve employer contributions (subsidy) at PEBP's budget closing hearing. (Damon Haycock, Executive Officer) (**For Possible Corrective Action**)

BOARD ACTION ON ITEM 6.
MOTION: Motion to approve Agenda Item 6.
BY: Member Mandy Hagler
SECOND: Member Leah Lamborn
VOTE: Unanimous; the motion carried.

7. Discussion and possible action to delay the start of Open Enrollment from May 1st, 2019 to May 20th, 2019 and extend the end of Open Enrollment from May 31st, 2019 to June 7th, 2019 for Plan Year 2020 (July 1, 2019 – June 30, 2020). (Damon Haycock, Executive Officer) (**For Possible Corrective Action**)

BOARD ACTION ON ITEM 7.
MOTION: Motion to revise the open enrollment to May 20th to June 7th for Agenda Item 7.
BY: Member Leah Lamborn
SECOND: Member John Packham
VOTE: Unanimous; the motion carried.

8. Discussion and possible action regarding approval of PEBP contract amendments beginning Plan Year 2021 (July 1, 2020):

    8.1. Extend the HealthSCOPE Benefits contract to provide Flexible Spending Account (FSA) services for an additional 2 years through June 30, 2022.

    8.2. Extend the Unum contract to provide voluntary long-term care services for an additional 4 years through June 30, 2024; assess if Unum can join PEBP's voluntary platform through PEBP's vendor; or allow the Unum contract to expire without renewal on June 30, 2020.

    (Cari Eaton, Chief Financial Officer)(**For Possible Action**)

BOARD ACTION ON ITEM 8.1.
MOTION: Motion to approve Item 8.1.
BY: Member John Packham
SECOND: Member Mandy Hagler
VOTE: Unanimous; the motion carried.

BOARD ACTION ON ITEM 8.2.
MOTION: Motion to approve PEBP's recommendation to select option number one to consider this at the September meeting.
BY: Member Leah Lamborn
SECOND: Member John Packham
VOTE: Unanimous; the motion carried.

9. Update on PEBP's Fiscal Year 2020/2021 Budget Closing hearings at the 80th Legislative Session. (Cari Eaton, Chief Financial Officer) (Information/Discussion)

10. Discussion and possible action regarding American Cancer Society age and frequency recommendations for colonoscopies and the United States Preventive Services Task Force (USPSTF) age and frequency guidelines for mammograms for both the Consumer Driven Health Plan (CDHP) and Exclusive Provider Organization (EPO) plans for Plan Year 2020. (Nancy Spinelli, Quality Control Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 10.

MOTION: Motion to approve the revisions that were presented at the March 28th board meeting for mammogram and colonoscopy for wellness preventive screenings.
BY: Member Leah Lamborn
SECOND: Member Mandy Hagler
VOTE: Unanimous; the motion carried.

11. Executive Officer Report. (Damon Haycock, Executive Officer) (Information/Discussion)

12. Discussion and possible action regarding potential Board position, recommendations, and direction to staff about 2019 Legislative Bills that may impact PEBP, including the following:

    * Assembly Bill 185

    * Assembly Bill 469

    (Damon Haycock, Executive Officer) **(For Possible Action)**

BOARD ACTION ON ITEM 12.

- No action taken.

13. Public Comment

Public Comment in Carson City:

- Peggy Lear Bowen – Retiree Participant – wished to say thank you for all the hard work and efforts made and for listening to the needs of the members.

14. Adjournment

Chair Contine adjourned the meeting at 9:55 a.m.

4.3.

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

   Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

   4.3. Receipt of quarterly staff reports for the period ending March 31, 2019:

      4.3.1. PEBP Chief Financial Officer Reports

         4.3.1.1. Budget Report

         4.3.1.2. Utilization Report

4.3.1.

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

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DAMON HAYCOCK
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: July 25, 2019

Item Number: IV.III.I.I.

Title: Chief Financial Officer Budget Report

Summary

This report addresses the Operational Budget as of March 31, 2019 to include:

1. Budget Status
2. Budget Totals
3. Claims Summary

Budget Account 1338 – Operational Budget – Shown below is a summary of the operational budget account status as of March 31, 2019 with comparisons to the same period in Fiscal Year 2018. The budget status is reported on a cash basis and does not include incurred expenses and income owed to the fund.

The budget status report reflects actual income of $278.3 million as of March 31, 2019 compared to $257.5 million as of March 31, 2018 or an increase of 8.1%. Total expenses for the period have decreased by $5.5 million or 2% for the same period.

The budget status report shows Realized Funding Available (cash) at $155 million. This compares to $119.6 million for last year. After subtracting $51.8 million for reserves for Incurred but not Reported (IBNR) claims, $39.9 million for the Catastrophic Reserve and $31.7 million for the HRA Reserve, the remaining balance is $31.6 million in Excess reserves. The table below reflects the actual revenue and expenditures for the period.

Operational Budget 1338

	FISCAL YEAR 2019			FISCAL YEAR 2018		
	Actual as of 3/31/2019	Work Program	Percent	Actual as of 3/31/2018	Fiscal Year 2018 Close	Percent
Beginning Cash	143,129,728	143,129,728	100%	134,046,196	134,046,196	100%
Premium Income	269,852,064	384,570,407	70%	250,261,521	365,798,560	68%
All Other Income	8,472,586	1,884,806	450%	7,233,455	55,678,580	13%
Total Income	278,324,649	386,455,213	72%	257,494,976	421,477,139	61%
Personnel Services	1,918,136	2,695,176	71%	1,685,599	2,457,675	69%
Operating - Other than Personnel	1,572,186	2,392,466	66%	1,819,755	2,467,105	74%
Insurance Program Expenses	262,174,182	377,035,392	70%	267,687,738	360,212,838	74%
All Other Expenses	781,802	1,125,737	69%	750,033	1,007,397	74%
Total Expenses	266,446,306	383,248,771	70%	271,943,125	366,145,015	74%
Change in Cash	11,878,344	3,206,442		(14,448,149)	55,332,124	
REALIZED FUNDING AVAILABLE	155,008,072	146,336,170	106%	119,598,047	189,378,320	63%
Incurred But Not Reported Liability	(51,800,000)	(51,800,000)		(35,300,000)	(35,300,000)	
Catastrophic Reserve	(39,900,000)	(39,900,000)		(19,400,000)	(19,400,000)	
HRA Reserve	(31,676,056)	(31,676,056)		(30,167,672)	(30,167,672)	
NET REALIZED FUNDING AVAILABLE	31,632,016	22,960,114		34,730,375	104,510,648	

Current Budget Projections

The following table represents projections for FY 2019 based on data available as of March 31, 2019. The projection reflects total income to be less than budgeted by 1.5% ($521.4 million vs $529.6 million), total expenditures are projected to be less than budgeted by 3.7% ($369.1 million vs $383.2 million); total reserves are projected to be more than budgeted by 4% ($152.2 million vs $146.3 million).

Budgeted and Projected Income (Budget Account 1338)					
Description	**Budget**	**Actual 3/31/19**	**Projected**	**Difference**	
Carryforward	143,129,728	143,129,728	143,129,728	0	0.0%
State Subsidies	278,587,976	205,048,176	278,240,942	(347,034)	-0.1%
Non-State Subsidies	26,970,841	21,369,710	28,477,468	1,506,627	5.6%
Premium	79,011,590	43,434,177	58,128,684	(20,882,906)	-26.4%
All Other	1,884,806	8,472,586	13,401,154	11,516,348	611.0%
Total	529,584,941	421,454,377	521,377,976	(8,206,965)	-1.5%
Budgeted and Projected Expenses (Budget Account 1338)					
Description	**Budget**	**Actual 3/31/19**	**Projected**	**Difference**	
Operating	6,213,379	4,272,124	6,249,569	(36,190)	-0.6%
State Employee Ins Cost	267,524,373	190,106,402	255,899,869	11,624,504	4.3%
State Retirees Ins Cost	53,764,043	33,016,762	52,415,558	1,348,485	2.5%
Non-State Employees Ins Cost	192,165	63,146	100,263	91,902	47.8%
Non-State Retirees Ins Cost	20,859,393	10,821,197	15,901,448	4,957,945	23.8%
State Medicare Ret Ins Cost	18,975,657	16,851,224	22,140,598	(3,164,941)	-16.7%
Non-State Medicare Ret Ins Cost	15,719,761	11,315,452	16,438,966	(719,205)	-4.6%
Total Insurance Costs	377,035,392	262,174,182	362,896,702	14,138,690	3.7%
Total Expenses	383,248,771	266,446,306	369,146,272	14,102,500	3.7%
Restricted Reserves	123,376,056	123,376,056	128,475,731	(5,099,675)	-4.1%
Excess Reserves for Benefit Enhancements	22,960,114	31,632,016	23,755,973	(795,859)	-3.5%
Total Reserves	146,336,170	155,008,072	152,231,704	(5,895,534)	-4.0%
Total of Expenses and Reserves	529,584,941	421,454,377	521,377,976	8,206,966	1.5%

State Subsidies are projected to be less than the budgeted amount by $0.3 million (0.1%), Non-State Subsidies are projected to be more than budgeted by $1.5 million (5.6%), and Premium Income is projected to be less than budgeted by $20.9 million (26.4%). This overall decrease in projected revenue is due in part to a decrease in actual rates as compared to the budgeted rates as well as a decrease in average enrollment as compared to budgeted enrollment and a change in the mix of plan tiers. The mix of participants is as follows:

- 1.53% fewer state actives,
- 3.6% fewer state non-Medicare retirees,
- 11.1% fewer non-state actives,
- 4.7% fewer non-state, non-Medicare retirees
- 1.48% more state Medicare retirees, and
- 5.58% fewer non-state Medicare retirees.

Expenses for Fiscal Year 2019 are projected to be $14.1 million (3.7%) less than budgeted when changes to reserves are excluded. Operating expenses are projected to be less than budgeted by $0.03 million (0.6%). Employee and Retiree insurances costs are projected to be less than budgeted by $14.1 million (3.7%) when taken in total (see table above for specific information).

Total reserves for the year ending March 31, 2019 are projected to be $152.2 million. Reserves include $51.8 million for Incurred but not Reported (IBNR) claims, $39.9 million for the Catastrophic Reserve to insure plan solvency, $36.8 million in HRA reserves, and a balance in excess of the required reserves of $23.8 million.

Recommendations

None.

4.3.1.2.

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

   Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

   4.3. Receipt of quarterly staff reports for the period ending March 31, 2019:

      4.3.1. PEBP Chief Financial Officer Reports

         4.3.1.2. Utilization Report

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Expires 04/01/2021

DAMON HAYCOCK
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: July 25, 2019

Item Number: IV.III.I.II.

Title: Self-Funded CDHP and EPO Plan Utilization Report for the period ending March 31, 2019

This report addresses medical, dental, prescription drug and HSA/HRA utilization for the Plan Year ending March 31, 2019. Included are:

- Executive Summary – provides a utilization overview.
- HealthSCOPE CDHP Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- HealthSCOPE EPO Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- Express Scripts Utilization Report – provides details supporting the prescription drug information included in the Executive Summary.
- Health Plan of Nevada Utilization – see Appendix C for Plan Year 2019 utilization data.

Executive Summary

CONSUMER DRIVEN HEALTH PLAN (CDHP)

The Consumer Driven Health Plan (CDHP) experience for Q3 of Plan Year 2019 compared to Plan Year 2018 is summarized below.

- Population:
  - 1.7% increase for primary participants
  - 1.7% increase for primary participants plus dependents (members)
- Medical Cost:
  - 3.5% increase for primary participants
  - 3.4% increase for primary participants plus dependents (members)
- High Cost Claims:
  - There were 141 High Cost Claimants accounting for 31.5% of the total plan paid for Q3 in Plan Year 2019
  - 31.9% increase in High Cost Claimants per 1,000 members
  - 4.3% decrease in average High Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Neoplasms ($8.4 million) – 24.4% of paid claims
  - Injury and Poisoning ($5.1 million) – 10.9% of paid claims
  - Diseases of the Circulatory System ($3.8 million) – 10.9% of paid claims
- Emergency Room:
  - ER visits per 1,000 members decreased by 3%
  - Average paid per ER visit increased 2.9% from Q3 in Plan Year 2018
- Urgent Care:
  - Urgent Care visits per 1,000 members increased by 0.4%
  - Average paid per Urgent Care visit decreased 5.3% from Q3 in Plan Year 2018
- Network Utilization:
  - 95.8% of claims are from In-Network providers
  - In-Network utilization decreased 0.6% from Plan Year 2018
  - In-Network discounts increased 0.4% from Plan Year 2018
- Preventive Services:
  - Overall Preventive Services Compliance Rates increased or remained within 1% from Plan Year 2018 in all categories
- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims decreased 1.8%
    - Total Gross Claims Costs increased 6.5% ($2.1 million)
    - Average Total Cost per Claim increased 8.4%
      - From $86.97 to $94.24
  - Member:
    - Total Member Cost decreased 3.6%
    - Average Participant Share per Claim decreased 1.8%
    - Net Member PMPM decreased 5.2%
      - From $21.95 to $20.81

- Plan
  - Total Plan Cost increased 9.8%
  - Average Plan Share per Claim increased 11.8%
  - Net Plan PMPM increased 8%
    - From $65.35 to $70.57

PEBP PREMIER PLAN (EPO)

The PEBP Premier Plan (EPO) experience for Q3 of Plan Year 2019 is summarized below.

- Population:
  - Average of 4,653 primary participants
  - Average of 8,488 primary participants plus dependents (members)
- Medical Cost:
  - Primary participants cost $643 PEPM
  - Primary participants plus dependents (members) cost $352 PMPM
- High Cost Claims:
  - There were 28 High Cost Claimants accounting for 23% of the total plan paid for Q3 in Plan Year 2019
  - Total of 3.3 High Cost Claimants per 1,000 members
  - Total of $220,761 average High Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Neoplasms ($1.5M) – 25.1% of paid claims
  - Diseases of the Circulatory System ($1.1M) – 18.6% of paid claims
  - Endocrine; Nutritional; and Metabolic ($835k) – 13.6% of paid claims
- Emergency Room:
  - Total of 151 ER visits per 1,000 members
  - Average of $2,583 paid per ER visit
- Urgent Care:
  - Total of 257 Urgent Care visits per 1,000 members
  - Average of $131 paid per Urgent Care visit
- Network Utilization:
  - 98.2% of claims are from In-Network providers
- Preventive Services:

	Compliance %
Preventive Office Visit:	29.5%
Cholesterol Screening:	34.2%
Cervical Cancer Screening (Females 21-29)	27.2%
Cervical Cancer Screening (Females 30-65)	23.5%
Breast Cancer Screening (Females 40+)	36.2%
PSA (Prostate-specific antigen) Screening (Males 50+)	22.7%
Colorectal Screening (All 50+)	15.4%

- Prescription Drug Utilization (Compared to Q2 2019):
  - Overall:
    - Total Net Claims increased 0.9%
    - Total Gross Claims Costs increased 9% ($369k)
    - Average Total Cost per Claim increased 8%
      - From $98.67 to $106.61

- Member:
  - Total Member Cost decreased 16.1%
  - Average Participant Share per Claim decreased 16.8%
  - Net Member PMPM decreased 16.5%
    - From $27.41 to $22.90
- Plan
  - Total Plan Cost increased 14.1%
  - Average Plan Share per Claim increased 13.1%
  - Net Plan PMPM increased 13.6%
    - From $134.32 to $152.59

DENTAL PLAN

The Dental Plan experience for Q3 of Plan Year 2019 is summarized below.

- Dental Cost:
  - Total of $18,513,661 paid for Dental claims
    - Preventative claims account for 42.2% ($7.8 million)
    - Basic claims account for 29.2% ($5.4 million)
    - Major claims account for 21.2% ($3.9 million)
    - Periodontal claims account for 7.3% ($1.3 million)

HEALTH REIMBURSEMENT ARRANGEMENT

The table below provides a list of CDHP HRA account balances as of March 31, 2019.

HRA Account Balances as of March 31, 2019			
$Range	**# Accounts**	**Total Account Balance**	**Average Per Account Balance**
0	1,557	$ -	$ -
$.01 - $500.00	3,345	$ 659,192.04	$ 197.07
$500.01 - $1,000	2,089	$ 1,494,317.77	$ 715.33
$1,000.01 - $1,500	850	$ 1,055,004.40	$ 1,241.18
$1,500.01 - $2,000	460	$ 800,844.94	$ 1,740.97
$2,000.01 - $2,500	376	$ 852,602.50	$ 2,267.56
$2,500.01 - $3,000	255	$ 700,138.77	$ 2,745.64
$3,000.01 - $3,500	211	$ 679,827.53	$ 3,221.93
$3,500.01 - $4,000	162	$ 604,475.15	$ 3,731.33
$4,000.01 - $4,500	140	$ 594,107.66	$ 4,243.63
$4,500.01 - $5,000	150	$ 711,224.72	$ 4,741.50
$5,000.01 +	**843**	**$ 6,200,541.22**	**$ 7,355.33**
Total	**10,438**	**$ 14,352,276.70**	**$ 1,375.00**

CONCLUSION

The information in this report provides plan experience for the Consumer Driven Health Plan (CDHP) and the PEBP Premier Plan (EPO) for the third quarter of Plan Year 2019. The CDHP is seeing total plan paid costs increase slightly over Plan Year 2018. The EPO Plan, although still in its first year, is running better than expected. For HMO utilization and cost data please see the report provided in Appendix C.

PEBP staff and its partners continue to monitor data, research options and implement measures to provide cost savings to the plan while also providing the care our participants require.

Appendix A

Index of Tables
HealthSCOPE – CDHP Utilization Review for PEBP
July 1, 2018 – March 31, 2019

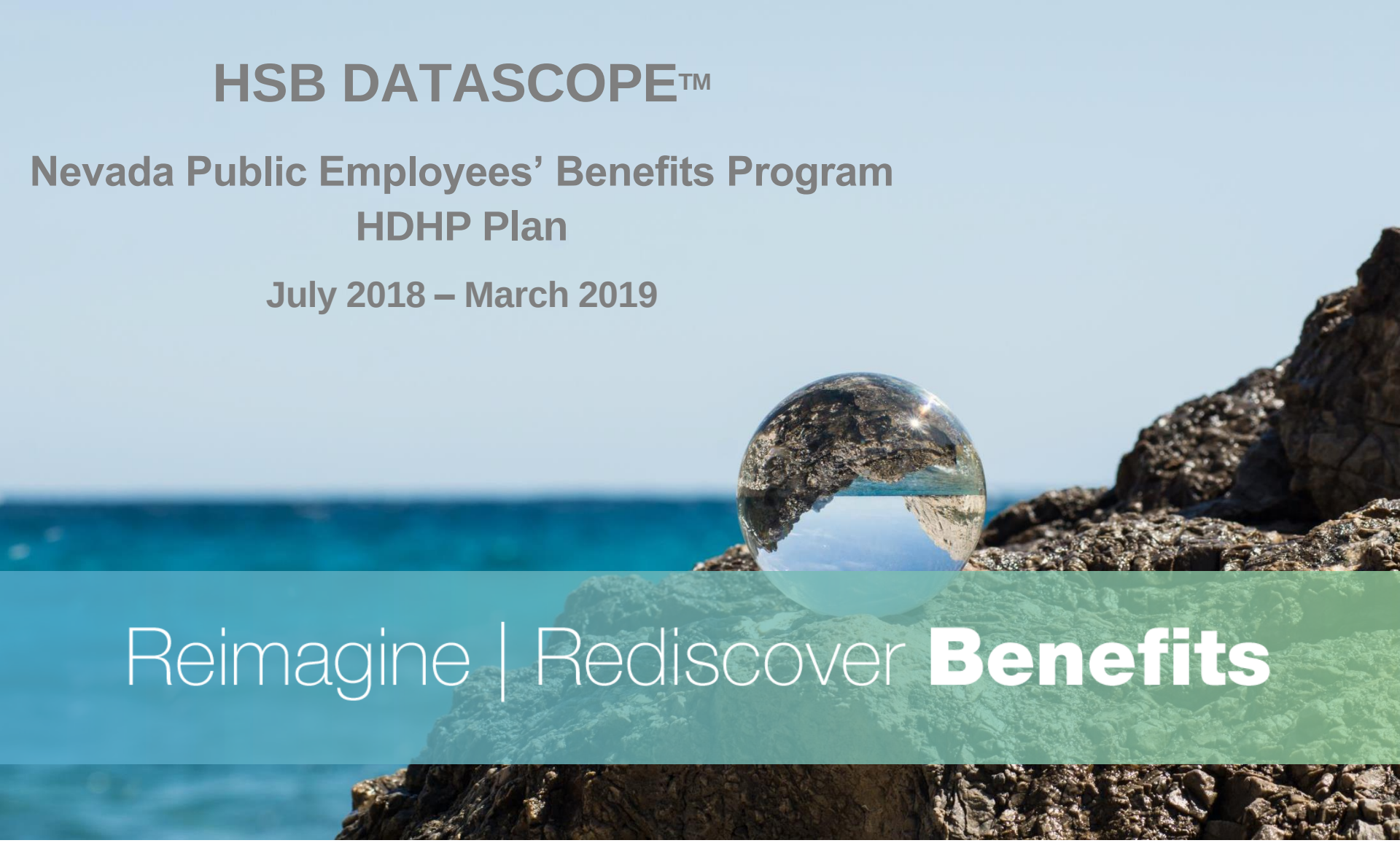
Appendix B

Index of Tables
HealthSCOPE – EPO Utilization Review for PEBP
July 1, 2018 – March 31, 2019

HSB DATASCOPE™

Nevada Public Employees' Benefits Program
HDHP Plan

July 2018 – March 2019



HealthSCOPE BENEFITS

Overview

- Total Medical Spend for 3Q19 was $94,830,736 of which 73.4% was spent in the State Active population. When compared to 3Q18, 3Q19 reflected an increase of 5.2% in plan spend.
  - When compared to 3Q17, 3Q19 reflected an increase of 8.5% in plan spend, with State Actives having an increase of 12.7%. This is relative to the increase in headcount.
- On a PEPY basis, 3Q19 reflected an increase of 3.5% when compared to 3Q18. The largest group, State Actives, increased slightly at 2.4%.
  - When compared to 3Q17, 3Q19 reflected a increase in PEPY of 4.1%, with State Actives increasing by 6.4%.
- 89.8% of the Average Membership had paid Medical claims less than $2,500, with 22.5% of those having no claims paid at all during the reporting period.
- There were 141 High Cost Claimants (HCC's) over $100K, that account for 31.5% of the total spend. HCC's accounted for 25.8% of total spend during 3Q18, with 105 members hitting the $100K threshold. The largest claimant had a primary diagnosis in the Injury & Poisoning Grouper, with plan spend of $1,411,483.
- IP Paid per Admit was $20,821 which is an increase of 14.5% over 3Q18 Paid per Admit of $18,185.
- ER Paid per Visit is $1,887, which is an increase of 2.9% from 3Q18 ER Paid per Visit of $1,834.
- 95.8% of all Medical spend dollars were to In Network providers. The average In Network discount was 64.7%, which is slightly higher than PY18 discount of 64.3%.

Paid Claims by Age Group (p. 1 of 2)

Paid Claims by Age Group									
	3Q18								
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Dental Net Pay	Dental PMPM	Net Pay	PMPM
<1	$ 4,411,101	$1,561	$ 17,698	$6	$ 3,539	$1	$ 4,432,338	$1,568
1	$ 620,427	$171	$ 8,799	$2	$ 33,498	$7	$ 662,724	$181
2 - 4	$ 854,483	$72	$ 54,806	$5	$ 289,265	$19	$ 1,198,554	$96
5 - 9	$ 1,117,758	$48	$ 160,020	$7	$ 925,087	$30	$ 2,202,865	$85
10 - 14	$ 1,970,566	$78	$ 228,372	$9	$ 921,543	$27	$ 3,120,481	$114
15 - 19	$ 2,416,583	$90	$ 519,478	$19	$ 1,102,849	$30	$ 4,038,910	$139
20 - 24	$ 2,750,086	$91	$ 624,577	$21	$ 780,811	$20	$ 4,155,474	$132
25 - 29	$ 2,815,738	$117	$ 482,395	$20	$ 755,068	$24	$ 4,053,201	$161
30 - 34	$ 3,992,809	$158	$ 620,546	$25	$ 916,384	$28	$ 5,529,739	$211
35 - 39	$ 4,606,522	$165	$ 1,254,446	$45	$ 1,021,052	$28	$ 6,882,020	$238
40 - 44	$ 4,673,664	$179	$ 1,209,538	$46	$ 1,012,686	$29	$ 6,895,888	$255
45 - 49	$ 6,819,835	$235	$ 2,050,582	$71	$ 1,172,788	$29	$ 10,043,205	$335
50 - 54	$ 9,082,333	$302	$ 3,518,053	$117	$ 1,407,573	$33	$ 14,007,959	$452
55 - 59	$ 11,104,466	$327	$ 3,575,946	$105	$ 1,694,975	$35	$ 16,375,387	$468
60 - 64	$ 22,806,586	$584	$ 5,668,518	$145	$ 2,064,801	$36	$ 30,539,905	$765
65+	$ 10,093,948	$525	$ 4,868,521	$253	$ 4,363,341	$40	$ 19,325,810	$818
Total	**$ 90,136,905**	**$ 238**	**$ 24,862,295**	**$ 66**	**$ 18,465,260**	**$ 31**	**$ 133,464,460**	**$ 335**

Paid Claims by Age Group (p. 2 of 2)

Paid Claims by Age Group																
	3Q19														% Change	
Age Range	Med Net Pay		Med PMPM		Rx Net Pay		Rx PMPM		Dental Net Pay		Dental PMPM		Net Pay		PMPM		Net Pay	PMPM
<1	$	5,240,277	$	1,759	$	25,493	$	9	$	3,727	$	1	$	5,269,497	$	1,769	-15.9%	-11.4%
1	$	482,100	$	139	$	31,336	$	9	$	33,637	$	7	$	547,073	$	155	21.1%	16.6%
2 - 4	$	823,194	$	68	$	58,526	$	5	$	305,875	$	19	$	1,187,595	$	92	0.9%	3.9%
5 - 9	$	1,133,889	$	49	$	242,226	$	10	$	917,085	$	29	$	2,293,200	$	89	-3.9%	-4.4%
10 - 14	$	2,790,226	$	110	$	229,974	$	9	$	899,175	$	26	$	3,919,375	$	145	-20.4%	-21.3%
15 - 19	$	3,734,186	$	137	$	607,634	$	22	$	1,124,398	$	30	$	5,466,218	$	190	-26.1%	-26.7%
20 - 24	$	5,114,682	$	166	$	564,135	$	18	$	738,719	$	19	$	6,417,536	$	203	-35.2%	-35.0%
25 - 29	$	3,268,700	$	131	$	658,787	$	26	$	723,886	$	23	$	4,651,373	$	181	-12.9%	-11.0%
30 - 34	$	5,012,192	$	190	$	850,063	$	32	$	847,702	$	25	$	6,709,957	$	248	-17.6%	-14.8%
35 - 39	$	4,579,926	$	155	$	1,118,833	$	38	$	1,007,385	$	26	$	6,706,144	$	219	2.6%	8.6%
40 - 44	$	4,084,118	$	153	$	1,776,657	$	67	$	1,032,720	$	29	$	6,893,495	$	249	0.0%	2.4%
45 - 49	$	7,341,156	$	249	$	2,628,176	$	89	$	1,195,744	$	29	$	11,165,076	$	368	-10.0%	-8.9%
50 - 54	$	9,972,479	$	327	$	2,834,092	$	93	$	1,356,008	$	32	$	14,162,580	$	452	-1.1%	0.0%
55 - 59	$	11,562,746	$	342	$	4,911,992	$	145	$	1,690,087	$	36	$	18,164,824	$	523	-9.9%	-10.5%
60 - 64	$	19,094,477	$	496	$	6,565,512	$	171	$	2,067,138	$	37	$	27,727,127	$	704	10.1%	8.7%
65+	$	10,596,389	$	528	$	4,135,782	$	206	$	4,570,375	$	39	$	19,302,546	$	774	0.1%	5.8%
Total	**$**	**94,830,736**	**$**	**246**	**$**	**27,239,217**	**$**	**71**	**$**	**18,513,661**	**$**	**30**	**$**	**140,583,615**	**$**	**348**	**-5.1%**	**-3.6%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**3Q17**	**3Q18**	**3Q19**	**Variance to PY18**	**3Q17**	**3Q18**	**3Q19**	**Variance to PY18**	**3Q17**	**3Q18**	**3Q19**	**Variance to PY18**
Enrollment												
Avg # Employees	22,570	23,133	23,523	1.7%	18,457	19,072	19,549	2.5%	5	4	4	0.0%
Avg # Members	40,677	42,024	42,747	1.7%	35,034	36,359	37,090	2.0%	7	7	7	0.0%
Ratio	1.8	1.8	1.8	1.1%	1.9	1.9	1.9	0.0%	1.5	1.7	1.8	2.9%
Financial Summary												
Gross Cost	$116,689,802	$121,095,837	$126,187,313	4.2%	$85,060,862	$91,012,617	$94,673,980	4.0%	$15,873	$36,985	$28,186	-23.8%
Client Paid	$87,412,728	$90,136,905	$94,830,736	5.2%	$61,739,702	$66,302,270	$69,590,772	5.0%	$11,559	$28,475	$21,172	-25.6%
Employee Paid	$29,277,074	$30,958,932	$31,356,576	1.3%	$23,321,159	$24,710,347	$25,083,207	1.5%	$4,314	$8,510	$7,014	-17.6%
Client Paid-PEPY	$5,164	$5,195	$5,375	3.5%	$4,460	$4,635	$4,746	2.4%	$3,303	$9,235	$7,057	-23.6%
Client Paid-PMPY	$2,865	$2,860	$2,958	3.4%	$2,350	$2,431	$2,502	2.9%	$2,274	$5,339	$4,033	-24.5%
Client Paid-PEPM	$430	$433	$448	3.5%	$372	$386	$396	2.6%	$275	$770	$588	-23.6%
Client Paid-PMPM	$239	$238	$246	3.4%	$196	$203	$208	2.5%	$189	$445	$336	-24.5%
High Cost Claimants (HCC's) > $100k												
# of HCC's	126	105	141	34.3%	68	67	88	31.3%	0	0	0	0.0%
HCC's / 1,000	3.1	2.5	3.3	31.9%	1.9	1.8	2.4	31.8%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$191,429	$221,352	$211,913	-4.3%	$181,999	$236,431	$216,402	-8.5%	$0	$0	$0	0.0%
HCC's % of Plan Paid	27.6%	25.8%	31.5%	22.1%	20.0%	23.9%	27.4%	14.6%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$934	$890	$1,048	17.8%	$698	$718	$844	17.5%	$0	$0	$937	0.0%
Facility Outpatient	$925	$934	$858	-8.1%	$763	$784	$717	-8.5%	$1,455	$1,351	$378	-72.0%
Physician	$922	$954	$987	3.5%	$823	$866	$891	2.9%	$773	$3,837	$2,596	-32.3%
Other	$84	$82	$65	-20.7%	$66	$63	$50	-20.6%	$45	$151	$121	0.0%
Total	$2,865	$2,860	$2,958	3.4%	$2,350	$2,431	$2,502	2.9%	$2,274	$5,339	$4,033	-24.5%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**3Q17**	**3Q18**	**3Q19**	**Variance to PY18**	**3Q17**	**3Q18**	**3Q19**	**Variance to PY18**	**HSB Peer Index**
Enrollment									
Avg # Employees	3,088	3,170	3,225	1.7%	1,020	887	745	-16.1%	
Avg # Members	4,517	4,681	4,803	2.6%	1,120	978	847	-13.3%	
Ratio	1.5	1.5	1.5	-0.7%	1.1	1.1	1.1	3.6%	1.8
Financial Summary									
Gross Cost	$22,120,930	$22,936,715	$24,697,760	7.7%	$9,492,137	$7,109,520	$6,787,387	-4.5%	
Client Paid	$17,571,774	$17,934,707	$19,493,426	8.7%	$8,089,693	$5,871,453	$5,725,366	-2.5%	
Employee Paid	$4,549,157	$5,002,008	$5,204,334	4.0%	$1,402,444	$1,238,067	$1,062,021	-14.2%	
Client Paid-PEPY	$7,587	$7,545	$8,060	6.8%	$10,576	$8,826	$10,253	16.2%	$6,209
Client Paid-PMPY	$5,187	$5,109	$5,412	5.9%	$9,631	$8,007	$9,008	12.5%	$3,437
Client Paid-PEPM	$632	$629	$672	6.8%	$881	$735	$854	16.2%	$517
Client Paid-PMPM	$432	$426	$451	5.9%	$803	$667	$751	12.6%	$286
High Cost Claimants (HCC's) > $100k									
# of HCC's	38	30	40	33.3%	20	13	13	0.0%	
HCC's / 1,000	8.4	6.4	8.3	30.1%	17.9	13.3	15.3	15.3%	
Avg HCC Paid	$207,593	$176,624	$203,103	15.0%	$192,778	$161,724	$208,635	29.0%	
HCC's % of Plan Paid	44.9%	29.5%	41.7%	41.4%	47.7%	35.8%	47.4%	32.4%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$2,030	$1,742	$1,963	12.7%	$3,888	$3,245	$4,793	47.7%	$1,057
Facility Outpatient	$1,647	$1,735	$1,685	-2.9%	$3,091	$2,654	$2,336	-12.0%	$1,145
Physician	$1,321	$1,411	$1,605	13.7%	$2,433	$2,005	$1,701	-15.2%	$1,122
Other	$190	$222	$159	-28.4%	$219	$103	$178	72.8%	$113
Total	$5,187	$5,109	$5,412	5.9%	$9,631	$8,007	$9,008	12.5%	$3,437
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	3Q18				3Q19				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 23,341,472	$ 5,483,184	$ 1,467,260	$ 30,291,917	$ 27,278,109	$ 6,209,937	$ 1,627,848	$ 35,115,894	15.9%
Outpatient	$ 42,960,798	$ 9,735,555	$ 1,248,707	$ 53,945,060	$ 42,312,663	$ 10,138,286	$ 1,517,355	$ 53,968,304	0.0%
Total - Medical	$ 66,302,270	$ 15,218,740	$ 2,715,967	$ 84,236,977	$ 69,590,772	$ 16,348,222	$ 3,145,204	$ 89,084,198	5.8%
Dental	$ 12,797,571	$ 1,394,144	$ 376,562	$ 14,568,277	$ 12,618,555	$ 1,501,902	$ 377,501	$ 14,497,957	-0.5%
Dental Exchange	$-	$-	$ 1,955,452	$ 1,955,452	$ -	$ -	$ 2,169,604	$ 2,169,604	11.0%
Total	**$79,099,841**	**$16,612,883**	**$5,047,981**	**$100,760,706**	**$ 82,209,327**	**$ 17,850,124**	**$ 5,692,308**	**$ 105,751,760**	**5.0%**

Net Paid Claims - Per Participant per Month	3Q18				3Q19				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 386	$ 661	$ 495	$ 421	$ 396	$ 695	$ 572	$ 435	3.2%
Dental	$ 54	$ 46	$ 56	$ 53	$ 52	$ 50	$ 56	$ 52	-1.4%
Dental Exchange	$-	$-	$ 48	$ 48	$ -	$ -	$ 48	$ 48	1.0%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	3Q18				3Q19				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient		$ 1,831,282	$ 736,294	$ 2,567,576	$ 8,420	$ 2,129,225	$ 1,089,969	$ 3,227,613	25.7%
Outpatient	$ 28,475	$ 3,000,491	$ 303,386	$ 3,332,352	$ 12,752	$ 2,117,747	$ 388,426	$ 2,518,925	-24.4%
Total - Medical	$ 28,475	$ 4,831,773	$ 1,039,680	$ 5,899,928	$ 21,172	$ 4,246,971	$ 1,478,395	$ 5,746,538	-2.6%
Dental	$ 1,797	$ 402,965	$ 155,674	$ 560,437	$ 2,428	$ 301,319	$ 155,940	$ 459,688	-18.0%
Dental Exchange	$-	$-	$ 1,381,094	$ 1,381,094	$ -	$ -	$ 1,386,412	$ 1,386,412	0.4%
Total	**$30,272**	**$5,234,738**	**$2,576,448**	**$7,841,459**	**$ 23,600**	**$ 4,548,291**	**$ 3,020,747**	**$ 7,592,638**	**-3.2%**

Net Paid Claims - Per Participant per Month	3Q18				3Q19				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 770	$ 827	$ 486	$ 736	$ 588	$ 969	$ 638	$ 853	15.9%
Dental	$ 25	$ 40	$ 44	$ 41	$ 34	$ 41	$ 42	$ 41	0.5%
Dental Exchange	$-	$-	$ 44	$ 44	$ -	$ -	$ 43	$ 43	-2.6%

Paid Claims by Claim Type – Total

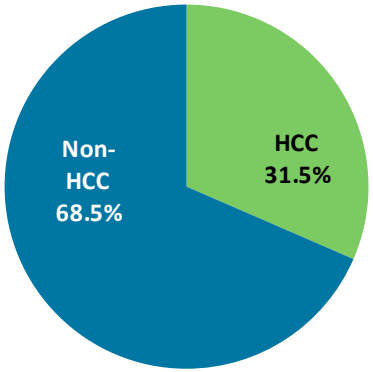
Net Paid Claims - Total Total Participants	3Q18				3Q19				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 23,341,472	$ 7,314,467	$ 2,203,554	$ 32,859,493	$ 27,286,529	$ 8,339,161	$ 2,717,817	$ 38,343,507	16.7%
Outpatient	$ 42,989,272	$ 12,736,046	$ 1,552,093	$ 57,277,412	$ 42,325,416	$ 12,256,032	$ 1,905,781	$ 56,487,229	-1.4%
Total - Medical	$ 66,330,745	$ 20,050,513	$ 3,755,647	$ 90,136,905	$ 69,611,944	$ 20,595,194	$ 4,623,599	$ 94,830,736	5.2%
Dental	$ 12,799,368	$ 1,797,109	$ 532,237	$ 15,128,714	$ 12,620,983	$ 1,803,221	$ 533,441	$ 14,957,645	-1.1%
Dental Exchange	$-	$-	$ 3,336,546	$ 3,336,546	$ -	$ -	$ 3,556,016	$ 3,556,016	6.6%
Total	**$ 79,130,113**	**$ 21,847,622**	**$ 7,624,430**	**$ 108,602,165**	**$ 82,232,928**	**$ 22,398,415**	**$ 8,713,055**	**$ 113,344,397**	**4.4%**

Net Paid Claims - Per Participant per Month	3Q18				3Q19				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Medical	$ 386	$ 694	$ 492	$ 433	$ 396	$ 738	$ 592	$ 448	3.4%
Dental	$ 54	$ 45	$ 52	$ 53	$ 52	$ 48	$ 51	$ 52	-2.2%
Dental Exchange	$-	$-	$ 46	$ 46	$ -	$ -	$ 46	$ 46	0.3%

Cost Distribution – Medical Claims

3Q18							3Q19					
Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid	Paid Claims Category	Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid
94	0.2%	$23,242,007	25.8%	$518,734	1.7%	$100,000.01 Plus	126	0.3%	$29,879,772	31.5%	$930,047	3.0%
170	0.4%	$13,206,280	14.7%	$939,989	3.0%	$50,000.01-$100,000.00	155	0.4%	$12,088,256	12.7%	$937,359	3.0%
315	0.8%	$12,201,260	13.5%	$1,683,200	5.4%	$25,000.01-$50,000.00	278	0.6%	$10,600,684	11.2%	$1,499,833	4.8%
907	2.2%	$14,625,807	16.2%	$4,186,588	13.5%	$10,000.01-$25,000.00	925	2.2%	$15,297,595	16.1%	$4,264,775	13.6%
1,292	3.1%	$9,620,561	10.7%	$4,124,029	13.3%	$5,000.01-$10,000.00	1,268	3.0%	$9,481,845	10.0%	$4,091,426	13.0%
1,629	3.9%	$6,109,545	6.8%	$3,845,823	12.4%	$2,500.01-$5,000.00	1,600	3.7%	$6,115,622	6.4%	$3,673,869	11.7%
21,707	51.7%	$11,131,444	12.3%	$12,994,953	42.0%	$0.01-$2,500.00	22,307	52.2%	$11,366,963	12.0%	$13,326,359	42.5%
6,577	15.6%	$0	0.0%	$2,665,616	8.6%	$0.00	6,455	15.1%	$0	0.0%	$2,632,908	8.4%
9,335	22.2%	$0	0.0%	$0	0.0%	No Claims	9,635	22.5%	$0	0.0%	$0	0.0%
42,024	**100.0%**	**$90,136,905**	**100.0%**	**$30,958,932**	**100.0%**		**42,747**	**100.0%**	**$94,830,736**	**100.0%**	**$31,356,576**	**100.0%**

Distribution of HCC Medical Claims Paid



HCC – High Cost Claimant over $100K

HCC's by AHRQ Clinical Classifications Chapter			
AHRQ Chapter	Patients	Total Paid	% Paid
(CCS 2) Neoplasms	75	$8,399,960	24.4%
(CCS 16) Injury And Poisoning	68	$5,076,831	10.9%
(CCS 7) Diseases Of The Circulatory System	97	$3,786,986	10.9%
(CCS 15) Certain Conditions Originating In The Perinatal Period	12	$2,826,264	7.7%
(CCS 13) Diseases Of The Musculoskeletal System And Connective Tissue	78	$1,579,071	6.0%
(CCS 5) Mental Illness	41	$1,216,118	5.1%
(CCS 1) Infectious And Parasitic Diseases	76	$1,215,268	4.8%
(CCS 9) Diseases Of The Digestive System	77	$1,037,582	3.6%
(CCS 10) Diseases Of The Genitourinary System	59	$824,931	2.8%
(CCS 8) Diseases Of The Respiratory System	90	$816,392	2.3%
(CCS 6) Diseases Of The Nervous System And Sense Organs	96	$768,239	2.2%
(CCS 17) Symptoms; Signs; And Ill-Defined Conditions And Factors Influencing Health Status	133	$714,617	1.8%
(CCS 3) Endocrine; Nutritional; And Metabolic Diseases And Immunity Disorders	79	$513,810	1.3%
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	78	$432,023	0.6%
(CCS 14) Congenital Anomalies	15	$322,383	0.5%
(CCS 12) Diseases Of The Skin And Subcutaneous Tissue	60	$162,755	0.3%
(CCS 4) Diseases Of The Blood And Blood-Forming Organs	40	$129,388	0.0%
(CCS 11) Complications Of Pregnancy; Childbirth; And The Puerperium	3	$106,576	0.0%
Overall	**----**	**$29,929,195**	**100.0%**

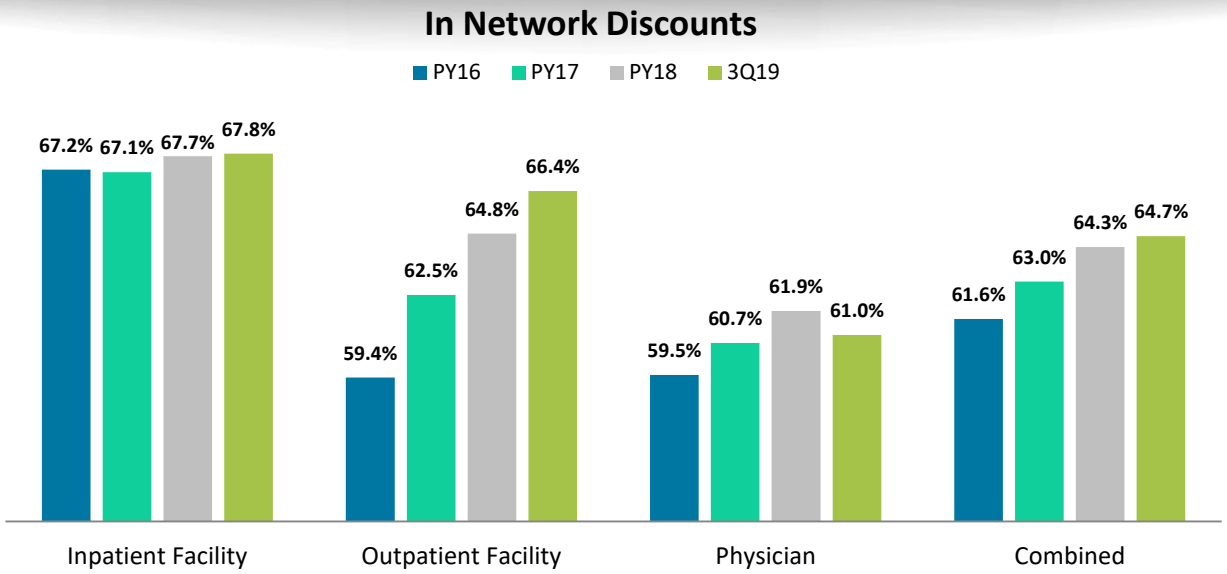
Utilization Summary (p. 1 of 2)

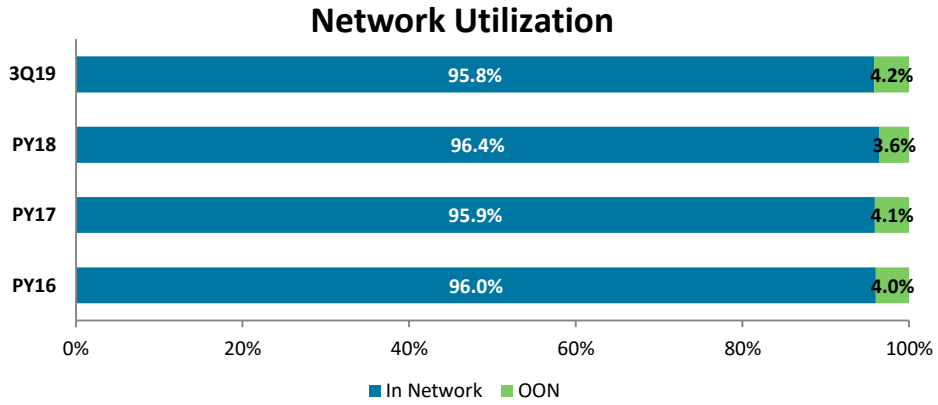
	Total				State Active				Non-State Active			
Summary	**3Q17**	**3Q18**	**3Q19**	**Variance to PY18**	**3Q17**	**3Q18**	**3Q19**	**Variance to PY18**	**3Q17**	**3Q18**	**3Q19**	**Variance to PY18**
Inpatient Facility												
# of Admits	1,656	1,620	1,667		1,221	1,235	1,294		0	0	1	
# of Bed Days	7,774	7,525	10,794		5,096	5,292	6,506		0	0	1	
Paid Per Admit	$17,929	$18,185	$20,821	14.5%	$15,952	$16,829	$19,082	13.4%	$0	$0	$4,922	0.0%
Paid Per Day	$3,819	$3,915	$3,216	-17.9%	$3,822	$3,927	$3,795	-3.4%	$0	$0	$4,922	0.0%
Admits Per 1,000	54	51	52	2.0%	46	45	47	3.4%	0	0	190	0.0%
Days Per 1,000	255	239	337	40.9%	194	194	234	20.6%	0	0	190	0.0%
Avg LOS	4.7	4.6	6.5	41.3%	4.2	4.3	5.0	16.3%	0	0	1	0.0%
Physician Office												
OV Utilization per Member	3.4	3.5	3.5	0.0%	3.2	3.3	3.2	-3.0%	5.1	10.3	5.0	-51.5%
Avg Paid per OV	$44	$44	$43	-2.3%	$43	$44	$43	-2.3%	$44	$83	$88	0.0%
Avg OV Paid per Member	$150	$155	$149	-3.9%	$135	$143	$137	-4.2%	$226	$860	$435	0.0%
DX&L Utilization per Member	7.3	7.4	7.4	0.0%	6.7	6.8	6.9	1.5%	10.4	9.6	7.6	0.0%
Avg Paid per DX&L	$61	$57	$62	8.8%	$57	$55	$57	3.6%	$80	$49	$61	0.0%
Avg DX&L Paid per Member	$442	$423	$461	9.0%	$380	$373	$389	4.3%	$830	$465	$463	0.0%
Emergency Room												
# of Visits	4,662	5,268	5,180		3,774	4,363	4,211		3	3	2	
# of Admits	750	784	813		501	562	594		0	0	1	
Visits Per Member	0.15	0.17	0.16	-5.9%	0.14	0.16	0.15	-6.3%	0.59	0.56	0.38	0.0%
Visits Per 1,000	153	167	162	-3.0%	144	160	151	-5.6%	590	563	381	0.0%
Avg Paid per Visit	$1,877	$1,834	$1,887	2.9%	$1,844	$1,808	$1,841	1.8%	$2,126	$1,027	$498	0.0%
Admits Per Visit	0.16	0.15	0.16	6.7%	0.13	0.13	0.14	7.7%	0.00	0.00	0.50	0.0%
Urgent Care												
# of Visits	7,347	7,272	7,442		6,599	6,488	6,672		5	2	4	
Visits Per Member	0.24	0.23	0.23	0.0%	0.25	0.24	0.24	0.0%	0.98	0.38	0.76	100.0%
Visits Per 1,000	241	231	232	0.4%	251	238	240	0.8%	983	375	762	103.2%
Avg Paid per Visit	$37	$38	$36	-5.3%	$33	$35	$35	0.0%	$83	$140	$102	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Utilization Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**3Q17**	**3Q18**	**3Q19**	**Variance to PY18**	**3Q17**	**3Q18**	**3Q19**	**Variance to PY18**	**HSB Peer Index**
Inpatient Facility									
# of Admits	298	277	284		137	108	88		
# of Bed Days	1,698	1,719	1,575		980	514	2,712		
Paid Per Admit	$22,480	$22,172	$24,476	10.4%	$25,651	$23,468	$34,777	48.2%	$16,173
Paid Per Day	$3,945	$3,573	$4,413	23.5%	$3,586	$4,931	$1,128	-77.1%	$3,708
Admits Per 1,000	88	79	79	-0.2%	163	147	138	-5.8%	61
Days Per 1,000	501	490	437	-10.8%	1,167	701	4,267	508.7%	264
Avg LOS	5.7	6.2	5.1	-17.7%	7.9	4.8	30.8	541.7%	4.3
Physician Office									
OV Utilization per Member	4.9	4.9	4.8	-2.0%	6.4	6.1	6.4	4.9%	3.3
Avg Paid per OV	$48	$47	$47	0.0%	$40	$38	$38	0.0%	$50
Avg OV Paid per Member	$234	$230	$224	-2.6%	$258	$231	$240	3.9%	$167
DX&L Utilization per Member	10.3	10.7	10.6	-0.9%	14.3	13.9	13.5	-2.9%	8.3
Avg Paid per DX&L	$73	$68	$85	25.0%	$79	$61	$79	29.5%	$67
Avg DX&L Paid per Member	$753	$722	$905	25.3%	$1,136	$840	$1,064	26.7%	$554
Emergency Room									
# of Visits	649	696	752		236	206	215		
# of Admits	173	169	160		76	53	58		
Visits Per Member	0.19	0.2	0.21	5.0%	0.28	0.28	0.34	21.4%	0.17
Visits Per 1,000	192	198	209	5.6%	281	281	338	20.3%	174
Avg Paid per Visit	$1,939	$2,027	$2,147	5.9%	$2,230	$1,755	$1,891	7.7%	$1,684
Admits Per Visit	0.27	0.24	0.21	-12.5%	0.32	0.26	0.27	3.8%	0.14
Urgent Care									
# of Visits	564	629	628		179	153	138		
Visits Per Member	0.17	0.18	0.17	-5.6%	0.21	0.21	0.22	4.8%	0.24
Visits Per 1,000	166	179	174	-2.8%	213	209	217	3.8%	242
Avg Paid per Visit	$66	$64	$47	-26.6%	$61	$49	$44	-10.2%	$74
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Provider Network Summary





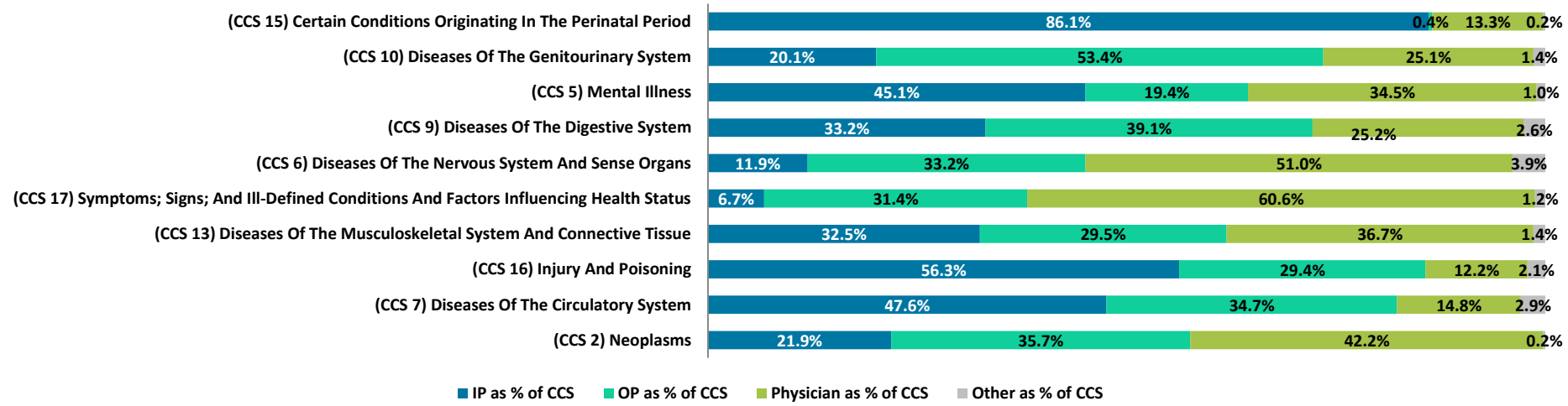
PEBP PY19 Additional Savings Total				
Savings Description	**1Q**	**2Q**	**3Q**	**PY19**
Non-Network Negotiations	$763,598	$810,847	$1,110,956	$2,685,401
Subrogation	$196,825	$327,641	$315,889	$840,354
Transplant Savings	$633,271	$470,386	$197,619	$1,301,276
Total Savings	**$1,593,694**	**$1,608,874**	**$1,624,464**	**$4,827,032**

AHRQ* Clinical Classifications Summary

*Developed at the Agency for Healthcare Research and Quality (AHRQ), the Clinical Classifications Software (CCS) is a tool for clustering patient diagnoses and procedures into a manageable number of clinically meaningful categories.

AHRQ Clinical Classifications Chapter	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
(CCS 2) Neoplasms	$14,808,273	15.8%	$12,371,010	$2,213,185	$224,079	$6,734,715	$8,073,558
(CCS 7) Diseases Of The Circulatory System	$10,222,877	10.4%	$7,658,668	$2,023,652	$540,556	$5,112,386	$5,110,491
(CCS 16) Injury And Poisoning	$10,177,743	10.2%	$5,746,237	$760,896	$3,670,610	$7,043,702	$3,134,041
(CCS 13) Diseases Of The Musculoskeletal System And Connective Tissue	$9,337,967	9.2%	$6,227,965	$1,784,215	$1,325,787	$4,086,394	$5,251,573
(CCS 17) Symptoms; Signs; And Ill-Defined Conditions And Factors Influencing Healt	$8,386,631	8.9%	$5,418,724	$1,293,131	$1,674,776	$3,074,494	$5,312,136
(CCS 6) Diseases Of The Nervous System And Sense Organs	$5,814,794	6.4%	$3,813,344	$1,099,606	$901,843	$2,128,350	$3,686,443
(CCS 9) Diseases Of The Digestive System	$5,654,263	6.3%	$4,029,792	$834,645	$789,826	$2,589,728	$3,064,535
(CCS 5) Mental Illness	$4,463,376	5.0%	$1,652,182	$693,645	$2,117,549	$1,956,955	$2,506,421
(CCS 10) Diseases Of The Genitourinary System	$4,366,724	4.9%	$2,866,100	$748,458	$752,166	$1,807,808	$2,558,916
(CCS 15) Certain Conditions Originating In The Perinatal Period	$3,927,801	4.5%	$10,375	$1,822	$3,915,604	$2,187,264	$1,740,537
(CCS 1) Infectious And Parasitic Diseases	$3,715,962	3.9%	$2,177,637	$441,270	$1,097,055	$2,067,658	$1,648,305
(CCS 8) Diseases Of The Respiratory System	$3,639,909	3.7%	$1,878,817	$572,280	$1,188,812	$1,890,509	$1,749,400
(CCS 11) Complications Of Pregnancy; Childbirth; And The Puerperium	$3,408,543	3.6%	$2,240,287	$950,447	$217,810	$10,115	$3,398,428
(CCS 3) Endocrine; Nutritional; And Metabolic Diseases And Immunity Disorders	$2,981,022	3.3%	$2,095,384	$451,196	$434,442	$1,181,616	$1,799,407
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	$1,494,870	1.1%	$1,123,722	$214,202	$156,946	$615,303	$879,568
(CCS 12) Diseases Of The Skin And Subcutaneous Tissue	$983,046	1.0%	$699,070	$161,217	$122,760	$595,060	$387,986
(CCS 14) Congenital Anomalies	$774,194	0.9%	$77,674	$9,200	$687,319	$473,318	$300,876
(CCS 4) Diseases Of The Blood And Blood-Forming Organs	$672,742	0.7%	$531,792	$77,650	$63,300	$171,837	$500,905
Total	**$94,830,736**	**100.0%**	**$60,618,781**	**$14,330,717**	**$19,881,238**	**$43,727,208**	**$51,103,528**

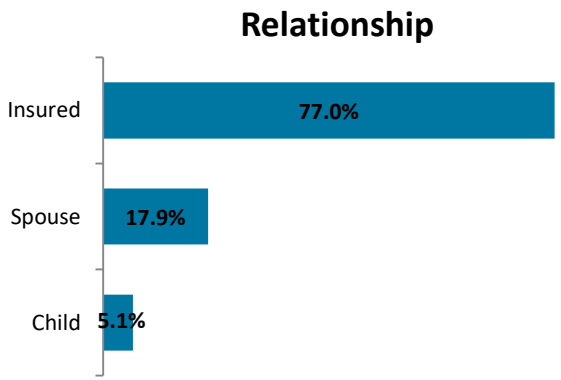
Top 10 Categories by Claim Type

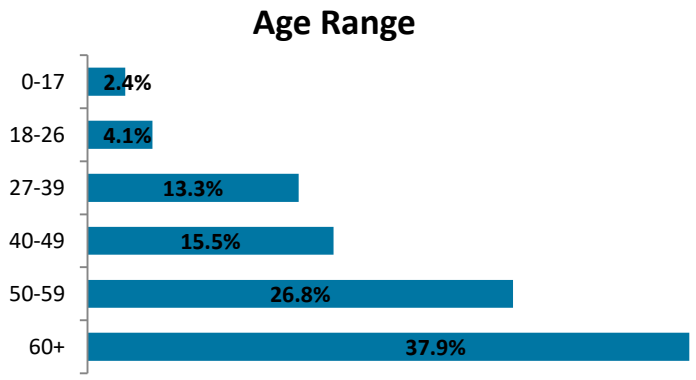


AHRQ Category - Neoplasms

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Cancer Of Lymphatic And Hematopoietic Tissue	110	1,622	$2,110,861	14.3%
Maintenance Chemotherapy; Radiotherapy [45.]	101	567	$2,038,403	13.8%
Cancer Of Breast [24.]	297	3,352	$1,976,288	13.3%
Cancer Of Skin	486	1,676	$1,937,435	13.1%
Benign Neoplasms	2,256	4,228	$1,487,975	10.0%
Cancer; Other Primary	188	1,590	$1,378,509	9.3%
Colorectal Cancer	73	668	$597,122	4.0%
Secondary Malignancies [42.]	107	672	$597,078	4.0%
Other Gastrointestinal Cancer	35	559	$595,087	4.0%
Cancer Of Uterus And Cervix	212	630	$489,934	3.3%
Neoplasms Of Unspecified Nature Or Uncertain Behavior [44.]	1,642	2,763	$405,908	2.7%
Cancer Of Male Genital Organs	146	774	$290,380	2.0%
Cancer Of Bronchus; Lung [19.]	36	343	$264,747	1.8%
Cancer Of Ovary And Other Female Genital Organs	50	321	$259,002	1.7%
Malignant Neoplasm Without Specification Of Site [43.]	24	143	$190,338	1.3%
Cancer Of Urinary Organs	62	348	$189,207	1.3%
Overall	**----**	**----**	**$14,808,273**	**100.0%**

*Patient and claim counts are unique only within the category

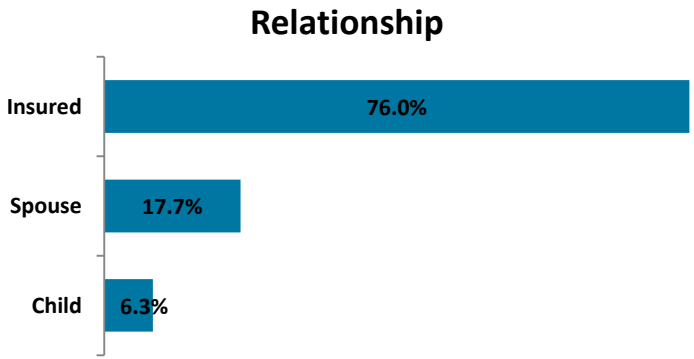


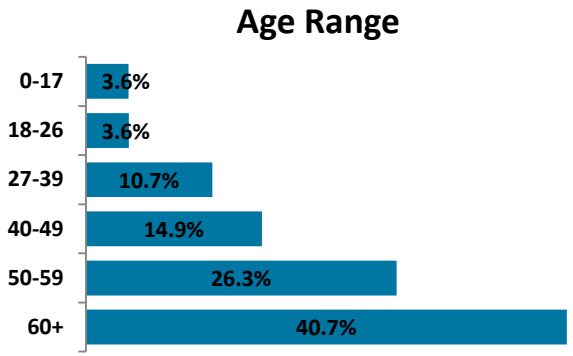


AHRQ Category – Diseases of the Circulatory System

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Diseases Of The Heart	3,069	12,534	$7,113,194	69.6%
Cerebrovascular Disease	357	1,433	$1,274,264	12.5%
Diseases Of Veins And Lymphatics	574	1,753	$867,954	8.5%
Hypertension	3,128	6,657	$667,681	6.5%
Diseases Of Arteries; Arterioles; And Capillaries	675	1,207	$299,784	2.9%
Overall	**----**	**----**	**$10,222,877**	**100.0%**

*Patient and claim counts are unique only within the category

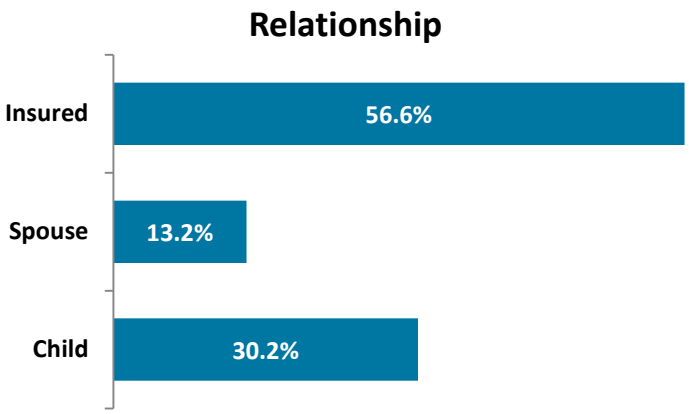


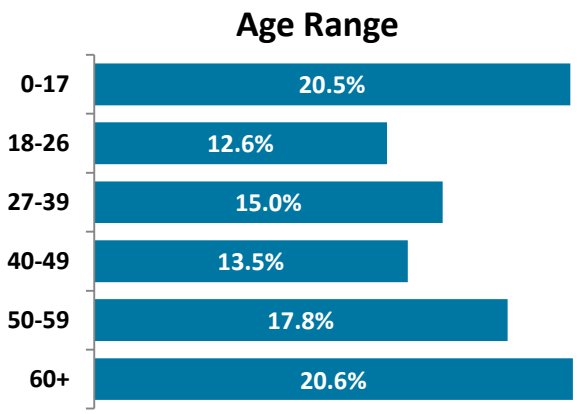


AHRQ Category – Injury & Poisoning

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Complications	512	1,821	$3,121,162	30.7%
Fractures	749	5,124	$2,152,660	21.2%
Intracranial Injury [233.]	126	544	$1,384,398	13.6%
Open Wounds	627	1,622	$1,136,480	11.2%
Sprains And Strains [232.]	1,320	4,921	$783,795	7.7%
Joint Disorders And Dislocations; Trauma-Related [225.]	606	2,560	$697,424	6.9%
Other Injuries And Conditions Due To External Causes [244.]	1,158	2,237	$479,105	4.7%
Superficial Injury; Contusion [239.]	666	1,219	$213,537	2.1%
Spinal Cord Injury [227.]	10	43	$112,538	1.1%
Crushing Injury Or Internal Injury [234.]	54	163	$45,419	0.4%
Poisoning	91	190	$34,004	0.3%
Burns [240.]	46	136	$17,222	0.2%
	----	----	$10,177,743	100.0%

*Patient and claim counts are unique only within the category

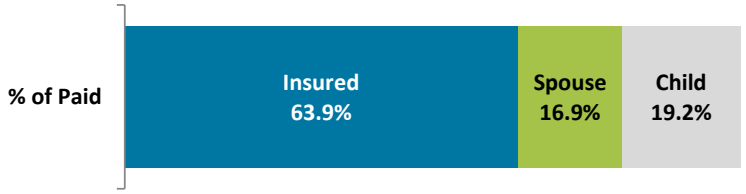




Emergency Room / Urgent Care Summary

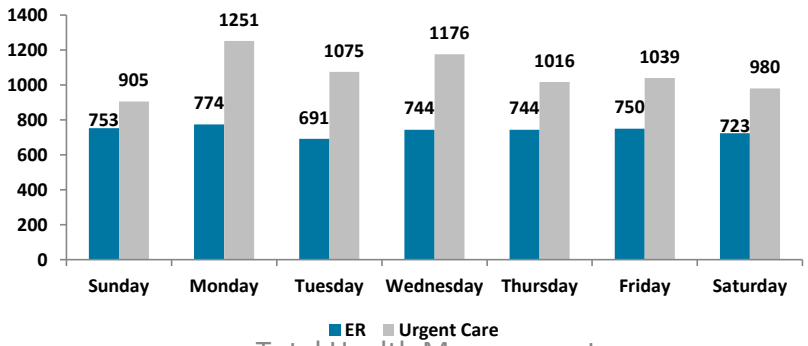
	3Q18		3Q19		HSB Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	5,268	7,272	5,179	7,442		
Number of Admits	784	----	813	----		
Visits Per Member	0.17	0.23	0.16	0.23	0.17	0.24
Visits/1000 Members	167	231	162	232	174	242
Avg Paid Per Visit	$1,833	$38	$1,886	$36	$1,684	$74
Admits per Visit	0.15	----	0.16	----	0.14	
% of Visits with HSB ER Dx	53.7%	----	76.8%	----		
% of Visits with a Physician OV*	76.7%	72.4%	77.5%	73.0%		
Total Plan Paid	**$9,658,223**	**$274,665**	**$9,767,091**	**$269,685**		

*looks back 12 months from ER visit



ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	3,000	128	4,387	186	7,387	314
Spouse	799	145	893	162	1,692	307
Child	1,380	101	2,162	158	3,542	258
Total	**5,179**	**121**	**7,442**	**174**	**12,621**	**295**

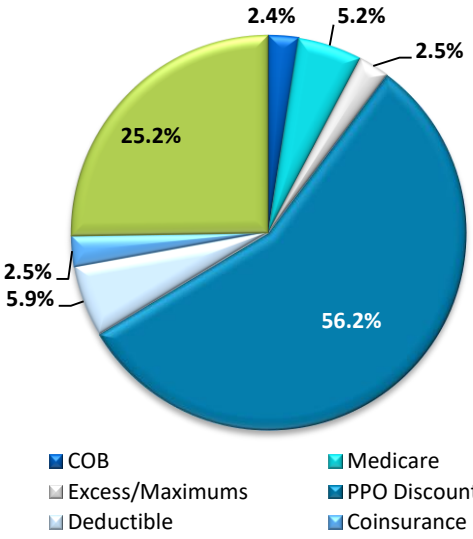
Visits by Day of Week

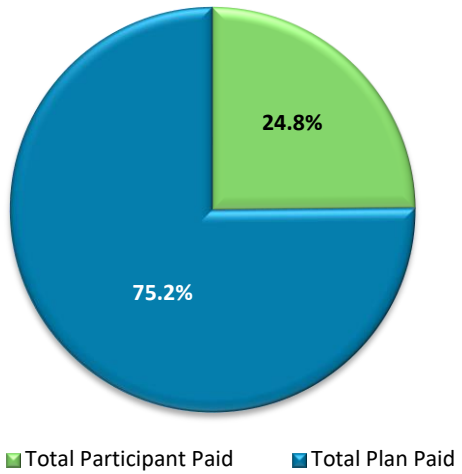


Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$375,578,363	$1,774	100.0%
COB	$9,141,576	$43	2.4%
Medicare	$19,679,658	$93	5.2%
Excess/Maximums	$9,538,101	$45	2.5%
PPO Discount	$211,031,715	$997	56.2%
Deductible	$22,038,095	$104	5.9%
Coinsurance	$9,318,481	$44	2.5%
Total Participant Paid	**$31,356,575**	**$148**	**8.3%**
Total Plan Paid	**$94,830,736**	**$448**	**25.2%**

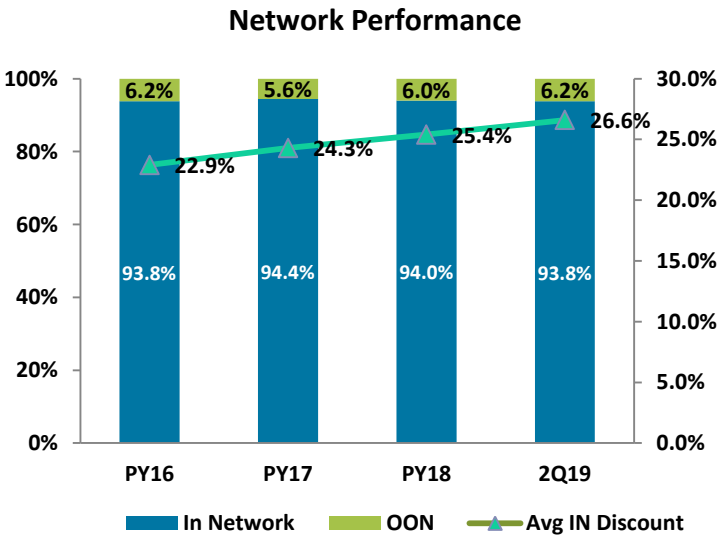
Total Participant Paid - PY18	**$141**
Total Plan Paid - PY18	**$450**



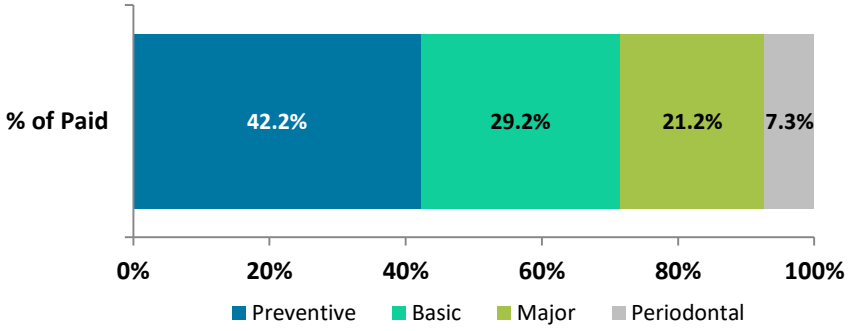


Dental Claims Analysis

Cost Distribution								
Paid Claims Category	Avg # of Members	% of Members	# Claims	# of Claims	Total Paid	% of Paid	Total EE Paid	% of EE Paid
$1,000.01 Plus	4,818	7.1%	21,146	20.2%	$7,184,283	38.8%	$4,699,775	52.5%
$750.01-$1,000.00	2,084	3.1%	7,545	7.2%	$1,846,079	10.0%	$1,028,773	11.5%
$500.01-$750.00	3,627	5.4%	11,485	11.0%	$2,279,865	12.3%	$1,211,699	13.5%
$250.01-$500.00	11,008	16.3%	29,379	28.1%	$3,815,773	20.6%	$1,062,797	11.9%
$0.01-$250.00	22,019	32.5%	34,426	32.9%	$3,387,660	18.3%	$932,302	10.5%
$0.00	471	0.7%	540	0.5%	$0	0.0%	$24,514	0.3%
No Claims	23,663	35.0%	0	0.0%	$0	0.0%	$0	-0.1%
Total	**67,689**	**100.0%**	**104,521**	**100.0%**	**$18,513,661**	**100.0%**	**$8,959,860**	**100.0%**



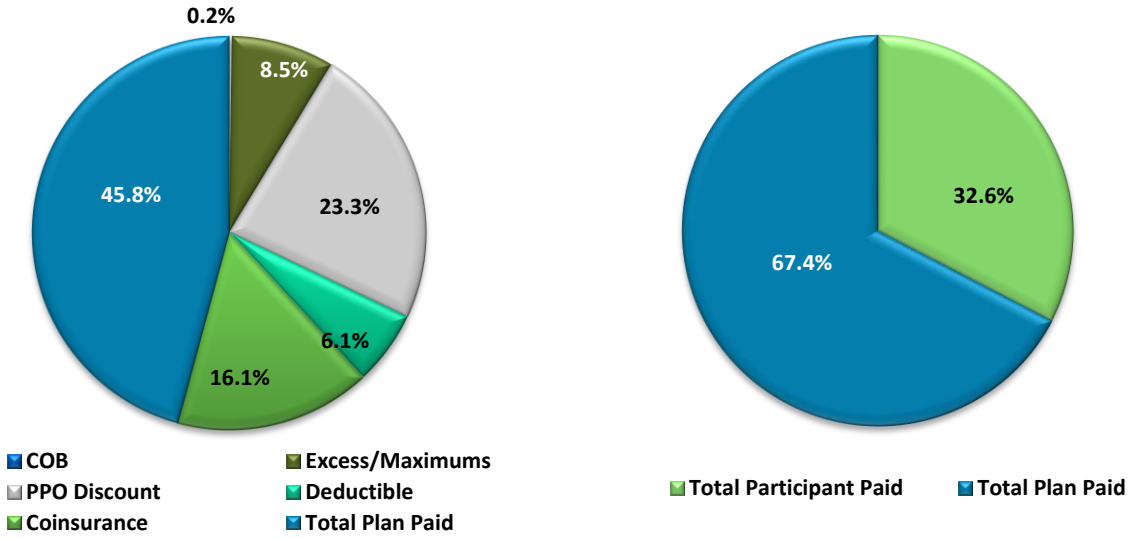
Claim Category	Total Paid	% of Paid
Preventive	$7,818,466	42.2%
Basic	$5,414,364	29.2%
Major	$3,933,520	21.2%
Periodontal	$1,347,311	7.3%
Total	**$18,513,661**	**100.0%**



Savings Summary – Dental Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$40,425,466	$66	100.0%
COB	$96,245	$0	0.2%
Excess/Maximums	$3,416,534	$6	8.5%
PPO Discount	$9,439,165	$15	23.3%
Deductible	$2,458,181	$4	6.1%
Coinsurance	$6,501,679	$11	16.1%
Total Participant Paid	**$8,959,860**	**$15**	**22.2%**
Total Plan Paid	**$18,513,661**	**$30**	**45.8%**

Total Participant Paid - PY18	**$14**
Total Plan Paid - PY18	**$31**



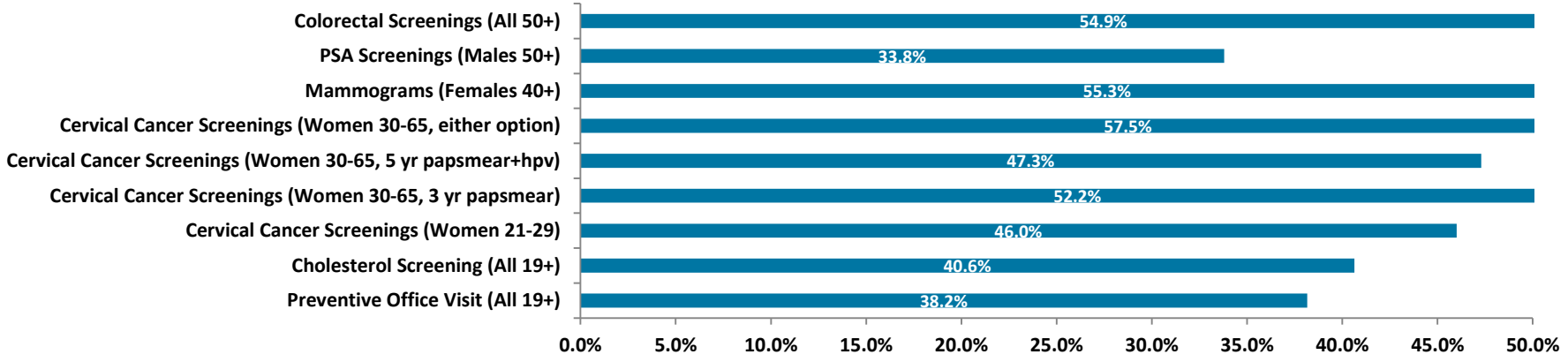
Preventive Services Compliance

*Based on 15 mo. of utilization/12 mo. paid data on members with 9 mo. of service or greater;

Colorectal screenings look back to July 2011.

	Female			Male			Total		
Service	Eligible	Compliant	% Compliant	Eligible	Compliant	% Compliant	Eligible	Compliant	% Compliant
Preventive Office Visit (All 19+)	16,995	8,565	50.4%	15,002	3,645	24.3%	31,997	12,211	38.2%
Cholesterol Screening (All 19+)	16,995	7,512	44.2%	15,002	5,491	36.6%	31,997	13,003	40.6%
Cervical Cancer Screenings (Women 21-29)	2,636	1,213	46.0%	----	----	----	2,636	1,213	46.0%
Cervical Cancer Screenings (Women 30-65, 3 yr papsmear)	12,874	6,720	52.2%	----	----	----	12,874	6,720	52.2%
Cervical Cancer Screenings (Women 30-65, 5 yr papsmear+hpv)	12,874	6,089	47.3%	----	----	----	12,874	6,089	47.3%
Cervical Cancer Screenings (Women 30-65, either option)	12,874	7,403	57.5%	----	----	----	12,874	7,403	57.5%
Mammograms (Females 40+)	10,634	5,881	55.3%	----	----	----	10,634	5,881	55.3%
PSA Screenings (Males 50+)	----	----	----	6,348	2,146	33.8%	6,348	2,146	33.8%
Colorectal Screenings (All 50+)	7,395	4,215	57.0%	6,348	3,333	52.5%	13,743	7,548	54.9%

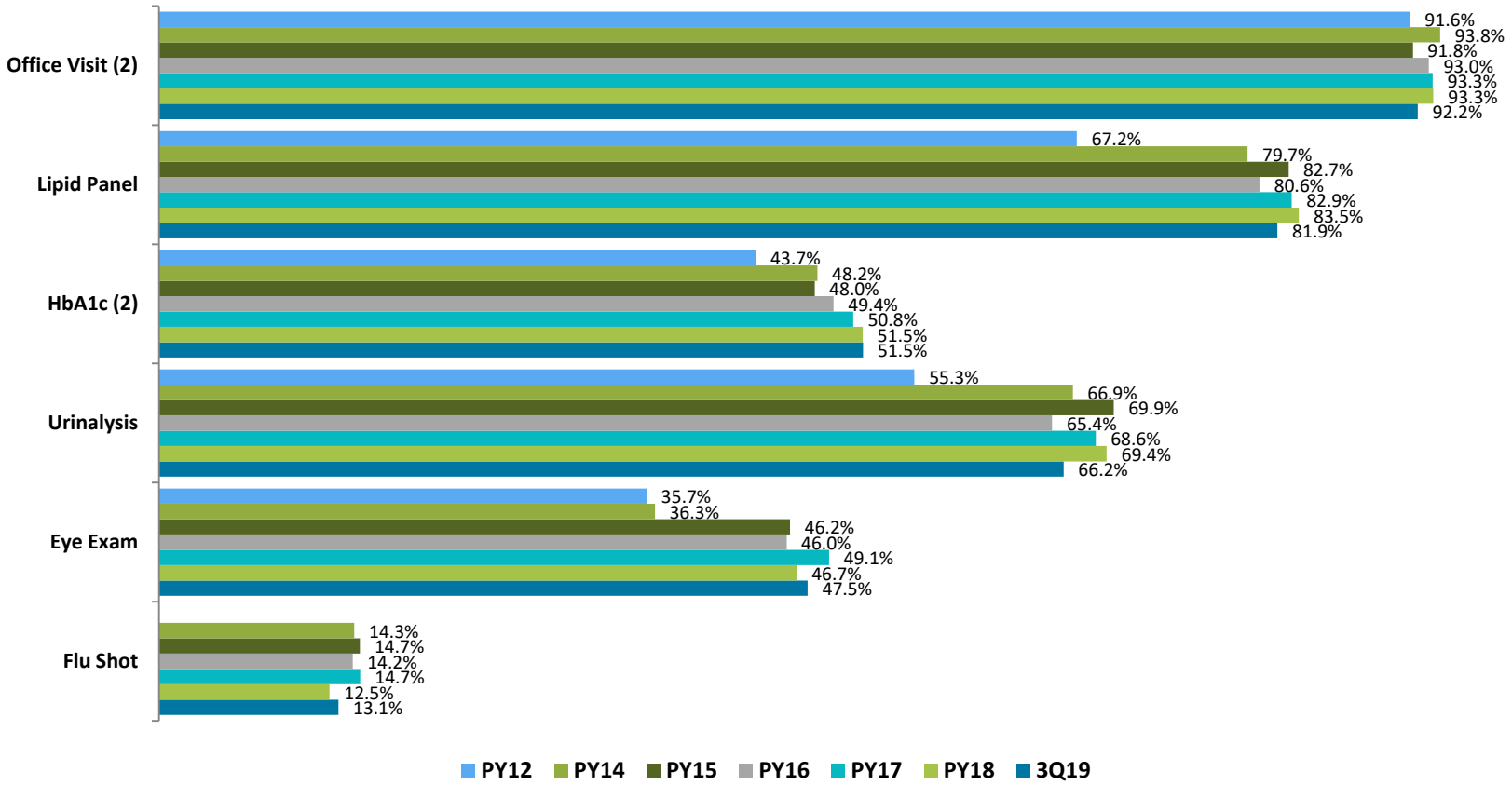
Overall Preventive Services Compliance Rates



Diabetic Disease Compliance

*Based on 15 mo. of utilization/12 mo. paid data on members with 9 mo. of service or greater;

Diabetic Population								
Year	PY12	PY13	PY14	PY15	PY16	PY17	PY18	3Q19
Members	1,651	1,643	1,555	1,676	1,693	1,704	1,747	1,750

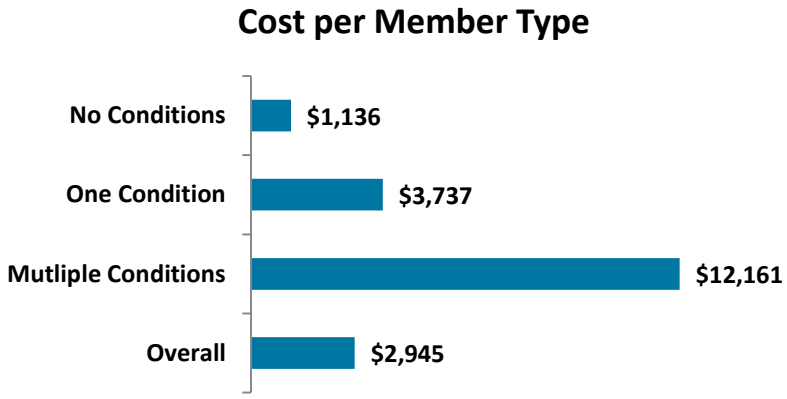


Chronic Conditions Summary

*Based on 15 mo. of utilization/12 mo. paid data on members with 9 mo. of service or greater;

Condition	Total Members	Avg Members	Per 1,000	Avg Age	Total Cost	Average Cost	Compliance Rate	Compliance Measure
Asthma	1,063	1,029	27	38	$7,062,857	$6,644	98.9%	1 Office Visit
Cancer	1,245	1,214	31	58	$26,163,565	$21,015	----	----
Chronic Kidney Disease	310	303	8	60	$5,914,127	$19,078	----	----
Chronic Obstructive Pulmonary Disease (COPD)	251	245	6	60	$6,007,388	$23,934	97.2%	1 Office Visit
Congestive Heart Failure (CHF)	126	120	3	62	$6,283,416	$49,868	13.5%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Coronary Artery Disease (CAD)	567	555	14	62	$9,207,301	$16,239	26.8%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Depression	1,287	1,243	33	41	$11,242,708	$8,736	96.3%	1 Office Visit
Diabetes	1,750	1,702	44	56	$15,286,104	$8,735	20.7%	2 Office Visits, 1 Lipid Profile, 2 HbA1c's, 1 Urinalysis, 1 Eye Exam, 1 Flu Shot
Hyperlipidemia	3,073	3,003	78	54	$15,442,190	$5,025	43.2%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Hypertension	3,377	3,292	85	57	$27,113,188	$8,029	29.9%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Obesity	725	706	18	44	$4,509,424	$6,220	----	----

# of Conditions	Avg Members	Average Age	Relationship		
			Insured	Spouse	Child
No Conditions	26,640	31	45.9%	11.0%	43.1%
One Condition	8,382	46	71.1%	16.2%	12.8%
Multiple Conditions	4,509	56	80.1%	17.4%	2.5%
Overall	**39,531**	**37**	**55.0%**	**12.8%**	**32.2%**



Public Employees' Benefits Program - RX Costs
PY 2019 - Quarter Ending March 31, 2019

Express Scripts

Membership Summary	3Q FY2019	3Q FY2018	Difference	% Change
			Membership Summary	
Member Count (Membership)	42,734	42,021	713	1.7%
Utilizing Member Count (Patients)	28,636	28,238	398	1.4%
Percent Utilizing (Utilization)	67.0%	67.2%	(0.00)	-0.3%

Claim Summary			Claims Summary	
Net Claims (Total Rx's)	372,959	379,622	(6,663)	-1.8%
Claims per Elig Member per Month (Claims PMPM)	0.97	1.00	(0.03)	-3.0%
Total Claims for Brand (Brand Rx)	51,106	51,723	(617.00)	-1.2%
Total Claims for Generic (Generic Rx)	321,853	327,899	(6,046.00)	-1.8%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	5,945	6,057	(112.00)	-1.8%
Total Non-Specialty Claims	396,766	376,836	19,930.00	5.3%
Total Specialty Claims	3,193	2,786	407.00	14.6%
Generic % of Total Claims (GFR)	**86.3%**	**86.4%**	(0.00)	-0.1%
Generic Effective Rate (GCR)	**98.2%**	**98.2%**	0.00	0.0%
Mail Order Claims	48,061	46,526	1,535.00	3.3%
Mail Penetration Rate*	14.8%	14.1%	0.01	0.7%

Claims Cost Summary			Claims Cost Summary	
Total Prescription Cost (Total Gross Cost)	$35,146,567.00	$33,014,627.00	$2,131,940.00	6.5%
Total Brand Gross Cost	$28,013,261.00	$25,653,021.00	$2,360,240.00	9.2%
Total Generic Gross Cost	$7,133,306.00	$7,361,606.00	($228,300.00)	-3.1%
Total MSB Gross Cost	$911,515.00	$721,320.00	$190,195.00	26.4%
Total Ingredient Cost	$34,855,003.00	$32,786,142.00	$2,068,861.00	6.3%
Total Dispensing Fee	$280,235.00	$215,162.00	$65,073.00	30.2%
Total Other (e.g. tax)	$11,329.00	$13,323.00	($1,994.00)	-15.0%
Avg Total Cost per Claim (Gross Cost/Rx)	$94.24	$86.97	$7.27	8.4%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$548.14	$495.97	$52.17	10.5%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$22.16	$22.45	($0.29)	-1.3%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$153.32	$119.09	$34.23	28.7%

Member Cost Summary			Member Cost Summary	
Total Member Cost	**$8,004,955.00**	**$8,300,141.00**	($295,186.00)	-3.6%
Total Copay	$3,566,248.00	$3,501,664.00	$64,584.00	1.8%
Total Deductible	$4,438,706.00	$4,798,478.00	($359,772.00)	-7.5%
Avg Copay per Claim (Copay/Rx)	$9.56	$9.22	$0.34	3.7%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$21.46**	**$21.86**	**($0.40)**	**-1.8%**
Avg Copay for Brand (Copay/Brand Rx)	$93.76	$91.79	$1.97	2.1%
Avg Copay for Generic (Copay/Generic Rx)	$9.98	$10.83	($0.85)	-7.8%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$70.84	$73.62	($2.78)	-3.8%
Net PMPM (Participant Cost PMPM)	**$20.81**	**$21.95**	($1.13)	-5.2%
Copay % of Total Prescription Cost (Member Cost Share %)	22.8%	25.1%	-2.4%	-9.4%

Plan Cost Summary			Plan Cost Summary	
Total Plan Cost (Plan Cost)	**$27,141,612.00**	**$24,714,486.00**	**$2,427,126.00**	**9.8%**
Total Specialty Drug Cost (Specialty Plan Cost)	$15,103,908.00	$13,196,083.00	$1,907,825.00	14.5%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$12,037,705.00	$11,518,403.00	$519,302.00	4.5%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$72.77**	**$65.10**	$7.67	11.8%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$454.38	$404.18	$50.20	12.4%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$12.18	$11.62	$0.56	4.8%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$82.48	$45.47	$37.01	81.4%
Net PMPM (Plan Cost PMPM)	**$70.57**	**$65.35**	**$5.22**	**8.0%**
PMPM for Specialty Only (Specialty PMPM)	$39.27	$34.89	$4.38	12.6%
PMPM without Specialty (Non-Specialty PMPM)	$31.30	$30.46	$0.84	2.8%

HSB DATASCOPE™

Nevada Public Employees' Benefits Program
EPO Plan

July 2018 – March 2019

HealthSCOPE BENEFITS

Overview

- Total Medical Spend for 3Q19 was $26,914,846 with an annualized plan cost per employee per year of $7,713. This is 24.2% above the HSB Book of Business Index.
  - IP Cost per Admit is $16,810 which is 3.9% higher than the HSB Index.
  - ER Cost per Visit is $2,538 which is 53.4% higher than the HSB Index.
- Employees shared in 10.5% of the medical cost.
- Inpatient facility costs were 31.6% of the plan spend.
- For the reporting period, 16.0% of members did not incur cost to the plan. Of that, 15.7% of total members did not have any claims paid by the plan at all during the reporting period.
- 28 members exceeded the $100k high cost threshold during the reporting period, which accounted for 23.0% of the plan spend. The highest diagnosis category was Diseases of the Musculoskeletal System, accounting for 11.1% of the high cost claimant dollars.
- Total spending with in-network providers was 98.2%. The overall in-network discount was 58.9%.

Paid Claims by Age Group

Paid Claims by Age Group										
3Q19										
Age Range	Med Net Pay		Med PMPM		Rx Net Pay		Rx PMPM		Net Pay		PMPM	
<1	$	959,138	$	1,225	$	6,468	$	8	$	965,606	$	1,233
1	$	180,231	$	220	$	9,519	$	12	$	189,750	$	232
2 - 4	$	263,722	$	112	$	11,702	$	5	$	275,424	$	117
5 - 9	$	363,327	$	78	$	69,194	$	15	$	432,521	$	93
10 - 14	$	913,790	$	158	$	170,828	$	30	$	1,084,618	$	188
15 - 19	$	1,096,983	$	178	$	192,096	$	31	$	1,289,079	$	210
20 - 24	$	650,338	$	126	$	296,014	$	58	$	946,352	$	184
25 - 29	$	870,651	$	282	$	214,414	$	69	$	1,085,065	$	351
30 - 34	$	2,188,478	$	540	$	238,748	$	59	$	2,427,226	$	599
35 - 39	$	1,457,833	$	302	$	470,185	$	97	$	1,928,018	$	400
40 - 44	$	1,636,719	$	341	$	529,082	$	110	$	2,165,801	$	451
45 - 49	$	1,742,757	$	277	$	1,022,893	$	163	$	2,765,650	$	440
50 - 54	$	3,399,275	$	491	$	1,398,741	$	202	$	4,798,016	$	692
55 - 59	$	3,878,339	$	477	$	1,789,841	$	220	$	5,668,180	$	697
60 - 64	$	5,843,549	$	651	$	2,089,076	$	233	$	7,932,625	$	883
65+	$	1,469,717	$	405	$	854,179	$	236	$	2,323,896	$	641
Total	**$**	**26,914,846**	**$**	**352**	**$**	**9,362,979**	**$**	**123**	**$**	**36,277,826**	**$**	**475**

Financial Summary

Summary	Total 3Q19	State Active 3Q19	Non-State Active 3Q19	State Retirees 3Q19	Non-State Retirees 3Q19	HSB Peer Index
Enrollment						
Avg # Employees	4,653	3,868	4	596	186	
Avg # Members	8,488	7,427	5	823	233	
Ratio	1.8	1.9	1.3	1.4	1.3	1.8
Financial Summary						
Gross Cost	$30,079,616	$24,034,079	$18,352	$4,350,351	$1,676,833	
Client Paid	$26,914,846	$21,402,296	$14,908	$3,941,348	$1,556,295	
Employee Paid	$3,164,770	$2,631,784	$3,445	$409,004	$120,538	
Client Paid-PEPY	$7,713	$7,378	$4,969	$8,824	$11,176	$6,209
Client Paid-PMPY	$4,228	$3,842	$3,975	$6,385	$8,914	$3,437
Client Paid-PEPM	$643	$615	$414	$735	$931	$517
Client Paid-PMPM	$352	$320	$331	$532	$743	$286
High Cost Claimants (HCC's) > $100k						
# of HCC's	28	18	0	7	3	
HCC's / 1,000	3.3	2.4	0.0	8.5	12.9	
Avg HCC Paid	$220,761	$216,987	$0	$183,419	$330,536	
HCC's % of Plan Paid	23.0%	18.2%	0.0%	32.6%	63.7%	
Cost Distribution by Claim Type (PMPY)						
Facility Inpatient	$951	$777	$0	$1,492	$4,615	$1,057
Facility Outpatient	$1,405	$1,293	$544	$2,102	$2,542	$1,145
Physician	$1,729	$1,652	$3,432	$2,454	$1,587	$1,122
Other	$142	$120	$0	$337	$170	$113
Total	$4,228	$3,842	$3,975	$6,385	$8,914	$3,437
	Annualized	Annualized	Annualized	Annualized	Annualized	

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	3Q19			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical				
Inpatient	$ 5,450,755	$ 1,012,651	$ 102,535	$ 6,565,941
Outpatient	$ 15,951,541	$ 2,515,971	$ 310,191	$ 18,777,702
Total - Medical	**$ 21,402,296**	**$ 3,528,622**	**$ 412,726**	**$ 25,343,643**

Net Paid Claims - Per Participant per Month	3Q19			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical	$ 615	$ 774	$ 513	$ 631

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	3Q19			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical				
Inpatient	$ 6,741	$ 851,160	$ 9,673	$ 867,574
Outpatient	$ 8,167	$ 595,593	$ 99,869	$ 703,629
Total - Medical	**$ 14,908**	**$ 1,446,753**	**$ 109,542**	**$ 1,571,203**

Net Paid Claims - Per Participant per Month	3Q19			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical	$ 414	$ 1,214	$ 229	$ 920

Paid Claims by Claim Type – Total

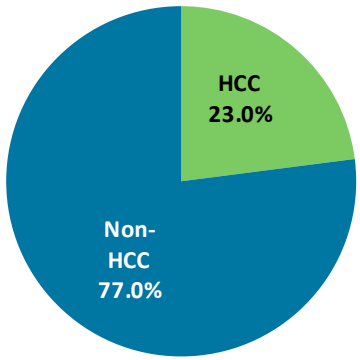
Net Paid Claims - Total				
Total Participants				
	3Q19			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical				
Inpatient	$ 5,457,496	$ 1,863,811	$ 112,208	$ 7,433,515
Outpatient	$ 15,959,708	$ 3,111,563	$ 410,060	$ 19,481,331
Total - Medical	**$ 21,417,203**	**$ 4,975,375**	**$ 522,268**	**$ 26,914,846**

Net Paid Claims - Per Participant per Month				
	3Q19			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical	$ 615	$ 866	$ 407	$ 643

Cost Distribution – Medical Claims

Paid Claims Category	3Q19 Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid
$100,000.01 Plus	24	0.3%	$6,131,879	22.8%	$187,200	5.9%
$50,000.01-$100,000.00	37	0.4%	$2,574,210	9.6%	$128,157	4.0%
$25,000.01-$50,000.00	93	1.1%	$3,446,786	12.8%	$234,028	7.4%
$10,000.01-$25,000.00	337	4.0%	$5,269,475	19.6%	$498,672	15.8%
$5,000.01-$10,000.00	417	4.9%	$3,038,525	11.3%	$448,417	14.2%
$2,500.01-$5,000.00	647	7.6%	$2,355,317	8.8%	$533,468	16.9%
$0.01-$2,500.00	5,574	65.7%	$4,098,654	15.2%	$1,126,939	35.6%
$0.00	24	0.3%	$0	0.0%	$7,887	0.2%
No Claims	1,334	15.7%	$0	0.0%	$0	0.0%
	8,488	**100.0%**	**$26,914,846**	**100.0%**	**$3,164,770**	**100.0%**

Distribution of HCC Medical Claims Paid



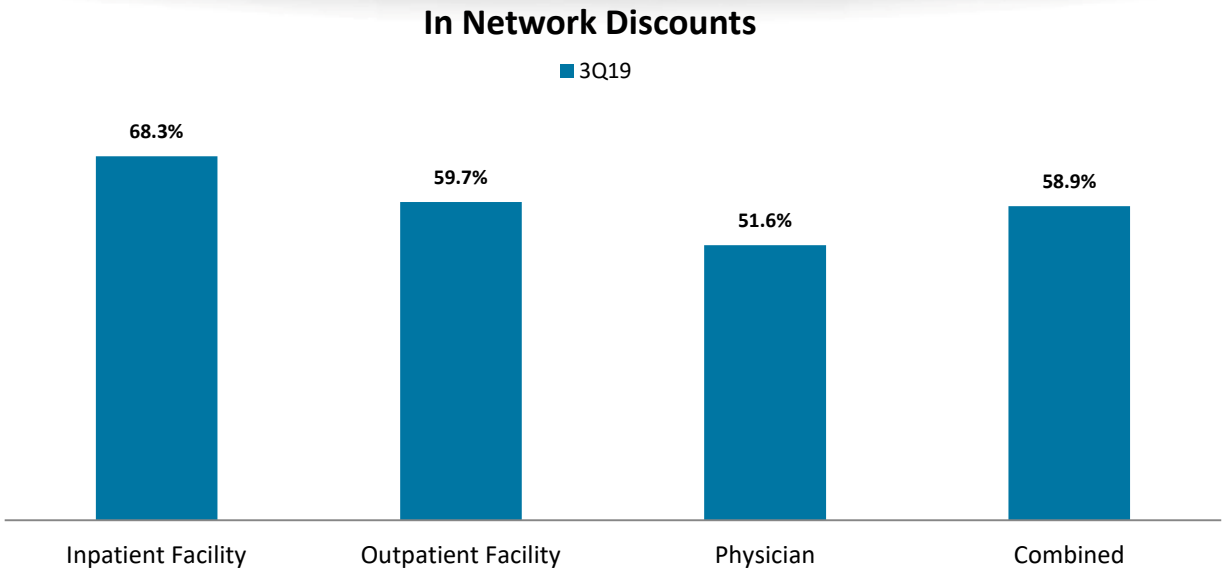
HCC – High Cost Claimant over $100K

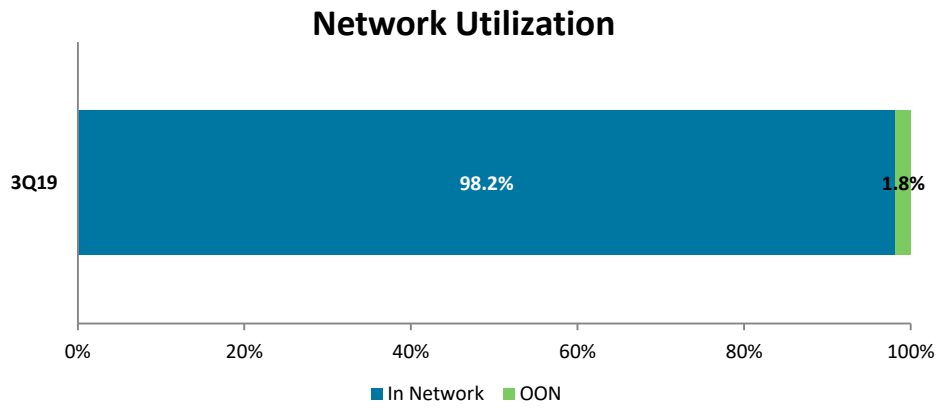
HCC's by AHRQ Clinical Classifications Chapter			
AHRQ Chapter	**Patients**	**Total Paid**	**% Paid**
(CCS 2) Neoplasms	15	$1,536,736	25.1%
(CCS 7) Diseases Of The Circulatory System	15	$1,138,043	18.6%
(CCS 3) Endocrine; Nutritional; And Metabolic Diseases And Immunity Disorders	13	$835,584	13.6%
(CCS 14) Congenital Anomalies	5	$389,703	6.4%
(CCS 8) Diseases Of The Respiratory System	20	$385,121	6.3%
(CCS 16) Injury And Poisoning	12	$363,153	5.9%
(CCS 1) Infectious And Parasitic Diseases	15	$305,245	5.0%
(CCS 5) Mental Illness	8	$251,853	4.1%
(CCS 15) Certain Conditions Originating In The Perinatal Period	3	$250,454	4.1%
(CCS 4) Diseases Of The Blood And Blood-Forming Organs	8	$223,918	3.7%
(CCS 13) Diseases Of The Musculoskeletal System And Connective Tissue	15	$159,101	2.6%
(CCS 10) Diseases Of The Genitourinary System	12	$118,032	1.9%
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	17	$63,897	1.0%
(CCS 6) Diseases Of The Nervous System And Sense Organs	17	$49,518	0.8%
(CCS 17) Symptoms; Signs; And Ill-Defined Conditions And Factors Influencing Health Status	27	$38,031	0.6%
(CCS 9) Diseases Of The Digestive System	12	$13,978	0.2%
(CCS 12) Diseases Of The Skin And Subcutaneous Tissue	9	$8,375	0.1%
(CCS 11) Complications Of Pregnancy; Childbirth; And The Puerperium	1	$1,137	0.0%
Overall	**----**	**$6,131,879**	**100.0%**

Utilization Summary

	Total	State Active	Non-State Active	State Retirees	Non-State Retirees	
Summary	**3Q19**	**3Q19**	**3Q19**	**3Q19**	**3Q19**	**HSB Peer Index**
Inpatient Facility						
# of Admits	356	305	0	38	13	
# of Bed Days	1,637	1,307	0	228	102	
Paid Per Admit	$16,810	$14,016	$0	$24,045	$61,977	$16,173
Paid Per Day	$3,656	$3,263	$0	$4,008	$7,899	$3,708
Admits Per 1,000	56	55	0	62	74	61
Days Per 1,000	257	234	0	369	584	264
Avg LOS	4.6	4.3	0	6	7.8	4.3
Physician Office						
OV Utilization per Member	4.1	4.0	5.9	5.3	4.6	3.3
Avg Paid per OV	$91	$92	$104	$82	$86	$50
Avg OV Paid per Member	$374	$367	$608	$435	$394	$167
DX&L Utilization per Member	8.1	7.6	15.2	11.2	12.4	8.3
Avg Paid per DX&L	$81	$78	$51	$91	$104	$67
Avg DX&L Paid per Member	$655	$594	$775	$1,023	$1,292	$554
Emergency Room						
# of Visits	962	829	0	107	26	
# of Admits	136	105	0	23	8	
Visits Per Member	0.15	0.15	0	0.17	0.15	0.17
Visits Per 1,000	151	149	0	173	149	174
Avg Paid per Visit	$2,583	$2,499	$0	$3,036	$3,378	$1,684
Admits Per Visit	0.14	0.13	0.00	0.21	0.31	0.14
Urgent Care						
# of Visits	1,637	1,496	0	106	35	
Visits Per Member	0.26	0.27	0.00	0.17	0.20	0.24
Visits Per 1,000	257	269	0	172	200	242
Avg Paid per Visit	$131	$133	$0	$119	$80	$74
	Annualized	Annualized	Annualized	Annualized	Annualized	

Provider Network Summary



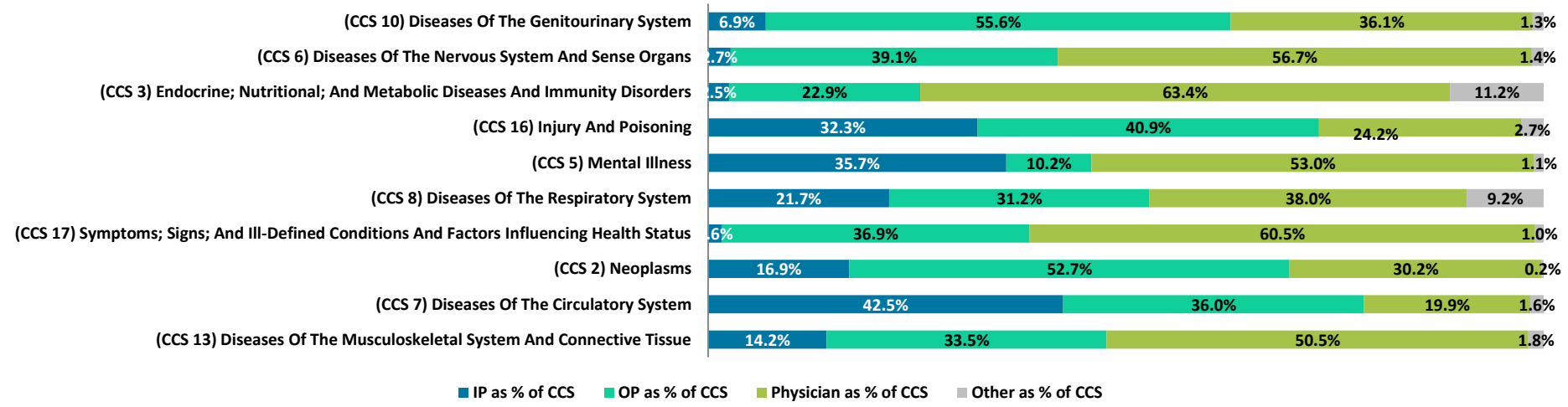


AHRQ* Clinical Classifications Summary

*Developed at the Agency for Healthcare Research and Quality (AHRQ), the Clinical Classifications Software (CCS) is a tool for clustering patient diagnoses and procedures into a manageable number of clinically meaningful categories.

AHRQ Clinical Classifications Chapter	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
(CCS 13) Diseases Of The Musculoskeletal System And Connective Tissue	$2,982,960	11.1%	$2,264,652	$593,784	$124,524	$1,080,372	$1,902,588
(CCS 7) Diseases Of The Circulatory System	$2,878,769	10.7%	$2,246,567	$566,699	$65,503	$1,891,486	$987,283
(CCS 2) Neoplasms	$2,624,721	9.8%	$2,132,136	$456,635	$35,950	$1,090,618	$1,534,103
(CCS 17) Symptoms; Signs; And Ill-Defined Conditions And Factors Influencing Healt	$2,209,440	8.2%	$1,358,853	$303,167	$547,420	$717,765	$1,491,674
(CCS 8) Diseases Of The Respiratory System	$2,020,354	7.5%	$1,243,212	$281,202	$495,940	$969,661	$1,050,692
(CCS 5) Mental Illness	$1,809,855	6.7%	$805,048	$136,525	$868,282	$645,050	$1,164,805
(CCS 16) Injury And Poisoning	$1,787,886	6.6%	$1,235,440	$247,686	$304,759	$1,014,745	$773,141
(CCS 3) Endocrine; Nutritional; And Metabolic Diseases And Immunity Disorders	$1,660,708	6.2%	$1,315,225	$103,692	$241,791	$536,609	$1,124,099
(CCS 6) Diseases Of The Nervous System And Sense Organs	$1,630,153	6.1%	$1,103,925	$261,528	$264,700	$575,565	$1,054,588
(CCS 10) Diseases Of The Genitourinary System	$1,454,313	5.4%	$1,116,563	$195,950	$141,800	$457,913	$996,400
(CCS 9) Diseases Of The Digestive System	$1,373,571	5.1%	$1,045,127	$132,031	$196,413	$474,574	$898,996
(CCS 11) Complications Of Pregnancy; Childbirth; And The Puerperium	$1,105,670	4.1%	$782,158	$240,649	$82,863	$3,787	$1,101,883
(CCS 1) Infectious And Parasitic Diseases	$825,584	3.1%	$561,906	$40,431	$223,247	$415,672	$409,912
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	$699,054	2.6%	$541,019	$133,120	$24,916	$328,468	$370,586
(CCS 14) Congenital Anomalies	$688,337	2.6%	$325,914	$4,178	$358,245	$557,944	$130,394
(CCS 15) Certain Conditions Originating In The Perinatal Period	$542,636	2.0%	$245	$266	$542,124	$354,183	$188,453
(CCS 12) Diseases Of The Skin And Subcutaneous Tissue	$315,100	1.2%	$231,473	$41,922	$41,705	$131,411	$183,689
(CCS 4) Diseases Of The Blood And Blood-Forming Organs	$305,735	1.1%	$75,335	$229,307	$1,093	$25,582	$280,153
Total	$26,914,846	100.0%	$18,384,798	$3,968,773	$4,561,274	$11,271,407	$15,643,439

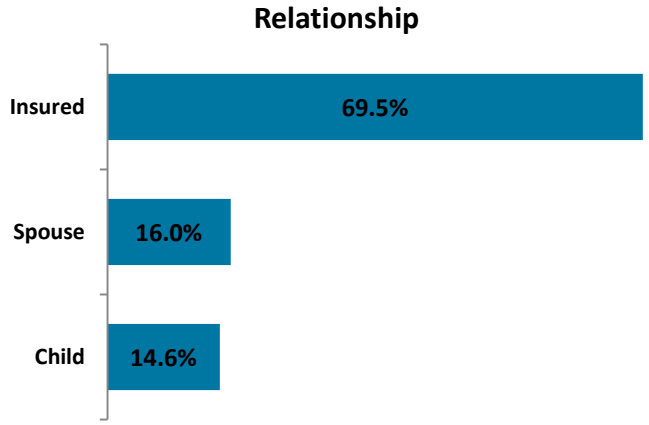
Top 10 Categories by Claim Type

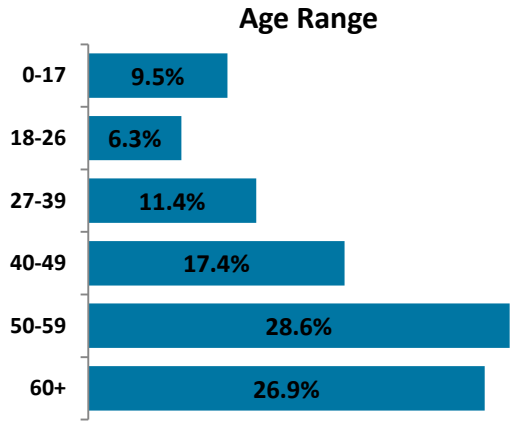


AHRQ Category – Diseases of the Musculoskeletal System & Connective Tissue

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Spondylosis; Intervertebral Disc Disorders; Other Back Problems [205.]	973	5,999	$1,161,256	38.9%
Non-Traumatic Joint Disorders	1,009	4,411	$940,078	31.5%
Other Connective Tissue Disease [211.]	862	2,754	$471,218	15.8%
Acquired Deformities	133	471	$165,795	5.6%
Other Bone Disease And Musculoskeletal Deformities [212.]	351	1,428	$77,847	2.6%
Pathological Fracture [207.]	6	30	$76,379	2.6%
Systemic Lupus Erythematosus And Connective Tissue Disorders [210.]	25	112	$61,435	2.1%
Infective Arthritis And Osteomyelitis (Except That Caused By Tb Or Std) [201.]	8	125	$15,006	0.5%
Osteoporosis [206.]	41	64	$13,946	0.5%
	----	----	$2,982,960	100.0%

*Patient and claim counts are unique only within the category

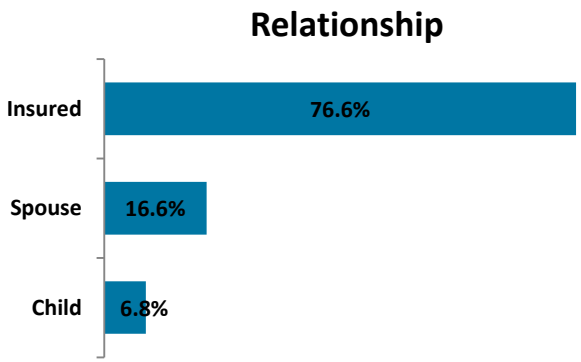


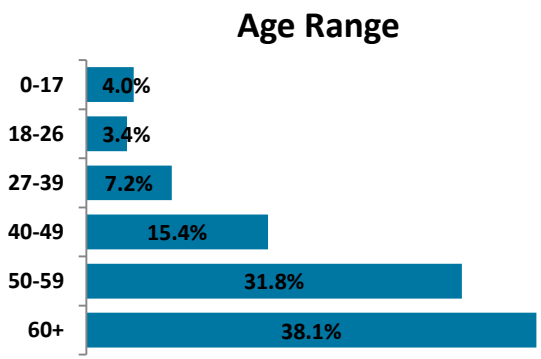


AHRQ Category – Diseases of the Circulatory System

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Diseases Of The Heart	606	2,324	$2,212,374	76.9%
Cerebrovascular Disease	63	333	$317,913	11.0%
Hypertension	606	1,136	$178,931	6.2%
Diseases Of Arteries; Arterioles; And Capillaries	127	237	$90,570	3.1%
Diseases Of Veins And Lymphatics	134	332	$78,981	2.7%
Overall	**----**	**----**	**$2,878,769**	**100.0%**

*Patient and claim counts are unique only within the category

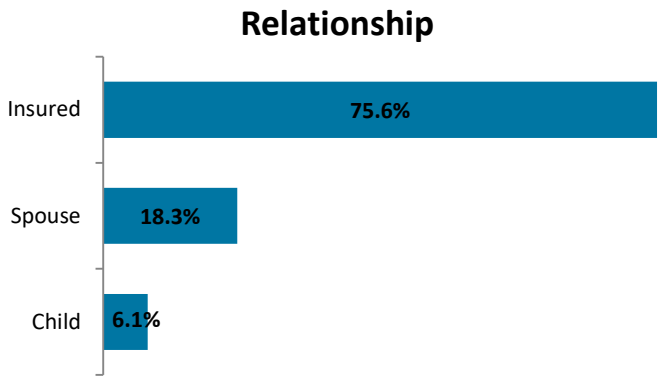


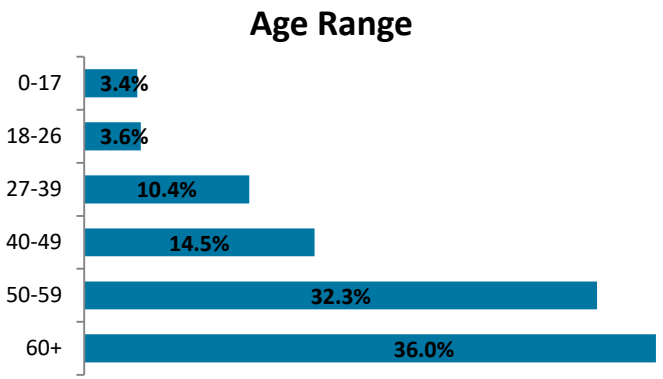


AHRQ Category - Neoplasms

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Cancer Of Breast [24.]	51	367	$523,880	20.0%
Cancer Of Lymphatic And Hematopoietic Tissue	23	434	$461,070	17.6%
Benign Neoplasms	473	821	$387,632	14.8%
Maintenance Chemotherapy; Radiotherapy [45.]	16	72	$348,736	13.3%
Cancer Of Urinary Organs	9	57	$205,197	7.8%
Cancer Of Bronchus; Lung [19.]	7	136	$166,223	6.3%
Secondary Malignancies [42.]	9	83	$120,513	4.6%
Cancer Of Male Genital Organs	28	89	$87,778	3.3%
Cancer; Other Primary	25	105	$72,027	2.7%
Cancer Of Skin	96	244	$69,947	2.7%
Neoplasms Of Unspecified Nature Or Uncertain Behavior [44.]	399	615	$67,487	2.6%
Other Gastrointestinal Cancer	4	46	$57,132	2.2%
Colorectal Cancer	5	37	$36,533	1.4%
Cancer Of Ovary And Other Female Genital Organs	5	19	$11,489	0.4%
Cancer Of Uterus And Cervix	21	40	$5,408	0.2%
Malignant Neoplasm Without Specification Of Site [43.]	5	10	$3,669	0.1%
Overall	**----**	**----**	**$2,624,721**	**100.0%**

*Patient and claim counts are unique only within the category

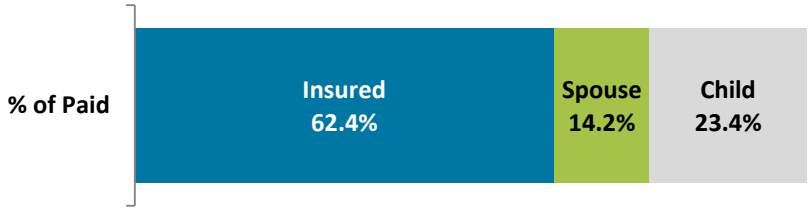




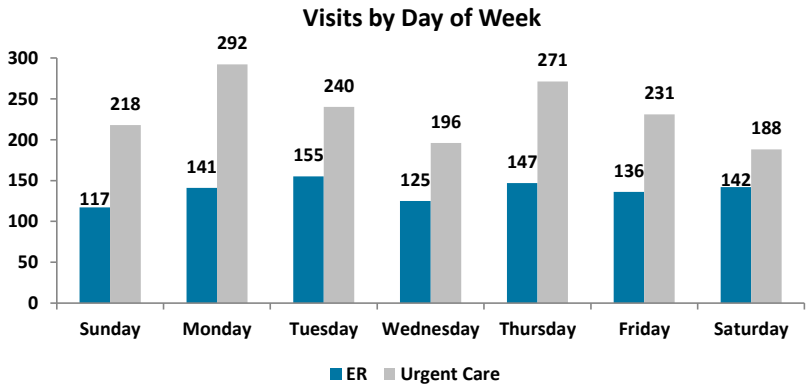
Emergency Room / Urgent Care Summary

	3Q19		HSB Peer Index	
ER/Urgent Care	ER	Urgent Care	ER	Urgent Care
Number of Visits	963	1,636		
Number of Admits	136	----		
Visits Per Member	0.15	0.26	0.17	0.24
Visits/1000 Members	151	257	174	242
Avg Paid Per Visit	$2,579	$131	$1,684	$74
Admits per Visit	0.14	----	0.14	
% of Visits with HSB ER Dx	79.4%	----		
% of Visits with a Physician OV*	63.1%	60.9%		
Total Plan Paid	**$2,483,265**	**$214,616**		

*looks back 12 months from ER visit



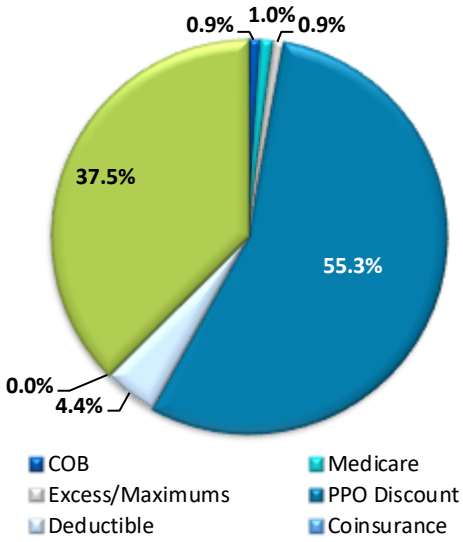
ER / UC Visits by Relationship						
Relationship	ER	Per 1,000	Urgent Care	Per 1,000	Total	Per 1,000
Insured	569	122	882	190	1,451	312
Spouse	115	122	178	189	293	311
Child	279	96	576	199	855	295
Total	**963**	**113**	**1,636**	**193**	**2,599**	**306**

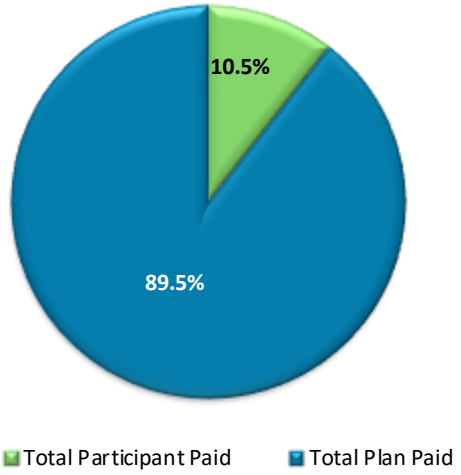


Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$71,813,891	$1,715	100.0%
COB	$670,168	$16	0.9%
Medicare	$727,657	$17	1.0%
Excess/Maximums	$615,519	$15	0.9%
PPO Discount	$39,720,931	$949	55.3%
Deductible	$3,164,699	$76	4.4%
Coinsurance	$71	$0	0.0%
Total Participant Paid	**$3,164,770**	**$76**	**4.4%**
Total Plan Paid	**$26,914,846**	**$643**	**37.5%**

Total Participant Paid - PY18	**$141**
Total Plan Paid - PY18	**$450**





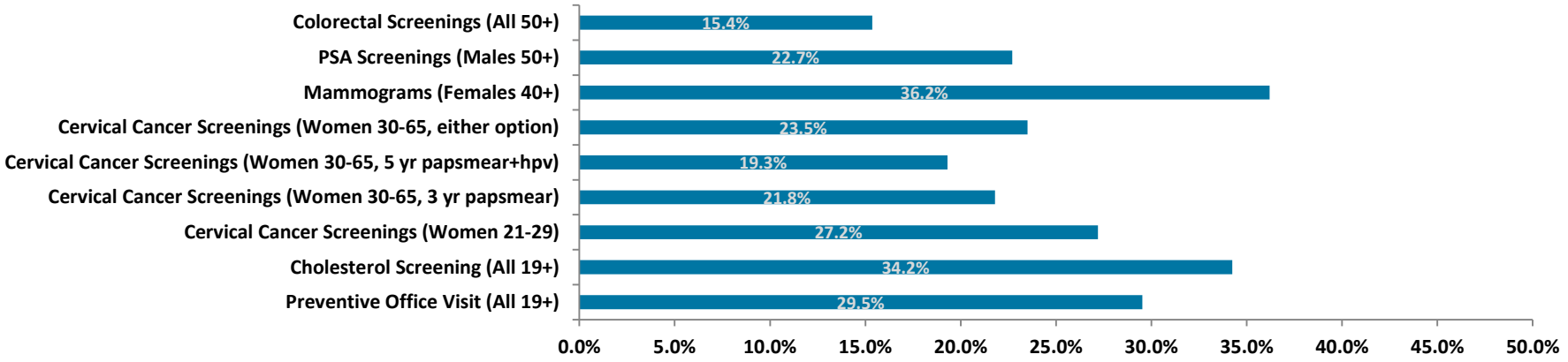
Preventive Services Compliance

*Based on 15 mo. of utilization/12 mo. paid data on members with 9 mo. of service or greater;

Colorectal screenings look back to July 2011.

	Female			Male			Total		
Service	Eligible	Compliant	% Compliant	Eligible	Compliant	% Compliant	Eligible	Compliant	% Compliant
Preventive Office Visit (All 19+)	3,347	1,265	37.8%	2,510	464	18.5%	5,857	1,730	29.5%
Cholesterol Screening (All 19+)	3,347	1,195	35.7%	2,510	811	32.3%	5,857	2,006	34.2%
Cervical Cancer Screenings (Women 21-29)	378	103	27.2%	----	----	----	378	103	27.2%
Cervical Cancer Screenings (Women 30-65, 3 yr papsmear)	2,694	587	21.8%	----	----	----	2,694	587	21.8%
Cervical Cancer Screenings (Women 30-65, 5 yr papsmear+hpv)	2,694	520	19.3%	----	----	----	2,694	520	19.3%
Cervical Cancer Screenings (Women 30-65, either option)	2,694	633	23.5%	----	----	----	2,694	633	23.5%
Mammograms (Females 40+)	2,295	831	36.2%	----	----	----	2,295	831	36.2%
PSA Screenings (Males 50+)	----	----	----	1,276	290	22.7%	1,276	290	22.7%
Colorectal Screenings (All 50+)	1,657	273	16.5%	1,276	177	13.9%	2,933	451	15.4%

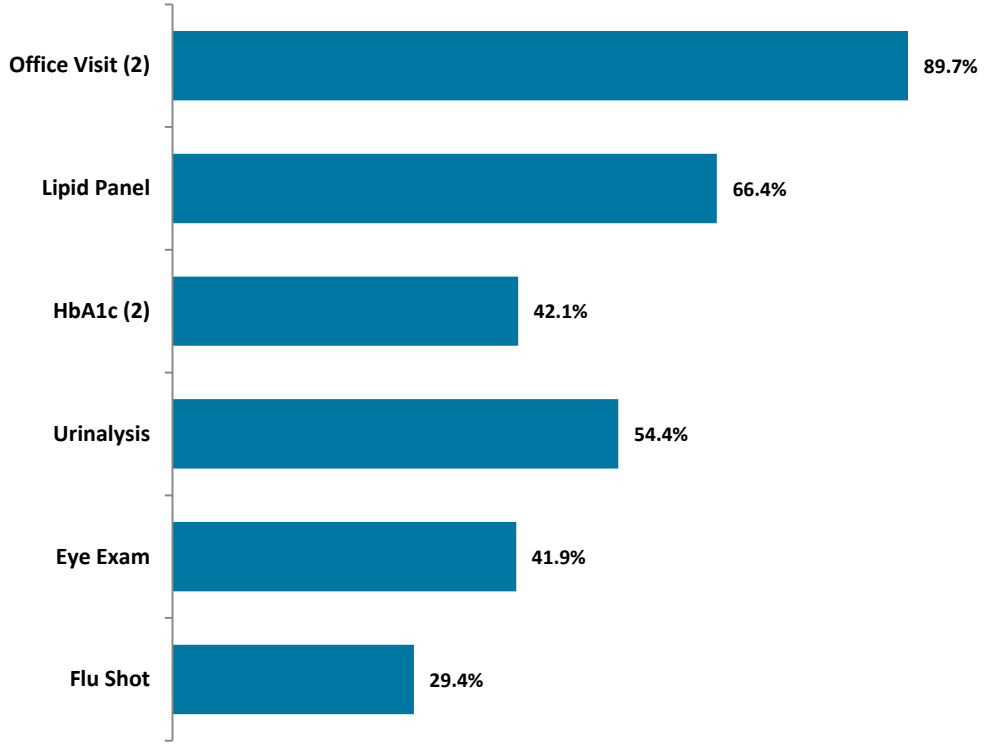
Overall Preventive Services Compliance Rates



Diabetic Disease Compliance

*Based on 15 mo. of utilization/12 mo. paid data on members with 9 mo. of service or greater;

Diabetic Population	
Year	3Q19
Members	425

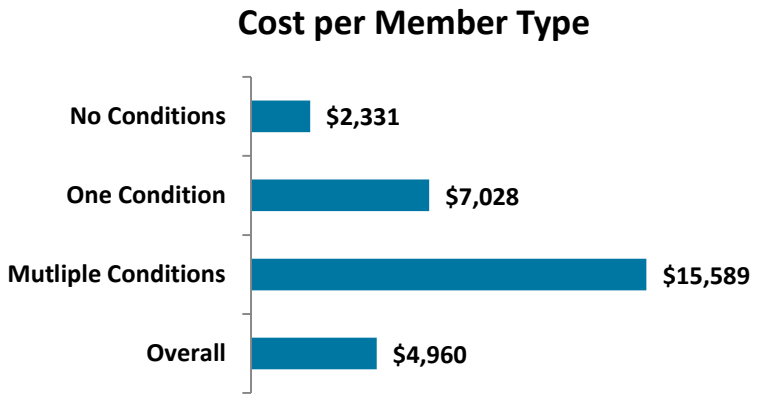


Chronic Conditions Summary

*Based on 15 mo. of utilization/12 mo. paid data on members with 9 mo. of service or greater;

Condition	Total Members	Avg Members	Per 1,000	Avg Age	Total Cost	Average Cost	Compliance Rate	Compliance Measure
Asthma	288	176	60	38	$1,384,878	$4,809	100.0%	1 Office Visit
Cancer	185	114	39	57	$3,285,336	$17,759	----	----
Chronic Kidney Disease	44	27	9	56	$743,092	$16,888	----	----
Chronic Obstructive Pulmonary Disease (COPD)	59	35	12	61	$870,383	$14,752	98.3%	1 Office Visit
Congestive Heart Failure (CHF)	22	13	5	53	$1,418,154	$64,462	9.1%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Coronary Artery Disease (CAD)	75	45	16	61	$996,489	$13,287	17.3%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Depression	392	246	82	42	$2,740,482	$6,991	95.2%	1 Office Visit
Diabetes	425	261	88	55	$2,356,958	$5,546	10.8%	2 Office Visits, 1 Lipid Profile, 2 HbA1c's, 1 Urinalysis, 1 Eye Exam, 1 Flu Shot
Hyperlipidemia	463	284	96	55	$2,308,774	$4,987	26.1%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Hypertension	555	342	116	56	$3,345,426	$6,028	18.4%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Obesity	170	106	35	48	$913,225	$5,372	0.0%	----

# of Conditions	Avg Members	Average Age	Relationship		
			Insured	Spouse	Child
No Conditions	3,134	32	44.9%	8.8%	46.3%
One Condition	1,113	47	71.5%	13.6%	14.9%
Multiple Conditions	559	54	81.9%	15.4%	2.8%
Overall	**4,805**	**38**	**55.4%**	**10.7%**	**34.0%**



Public Employees' Benefits Program - RX Costs
PY 2019 - Quarter Ending March 31, 2019

Express Scripts

Membership Summary	3Q FY2019 EPO	2Q FY2019 EPO	Difference	% Change
			Membership Summary	
Member Count (Membership)	8,509	8,472	37	0.4%
Utilizing Member Count (Patients)	5,250	5,294	(44)	-0.8%
Percent Utilizing (Utilization)	61.7%	62.5%	(0)	-1.3%

Claim Summary			Claims Summary	
Net Claims (Total Rx's)	42,018	41,659	359	0.9%
Claims per Elig Member per Month (Claims PMPM)	1.65	1.64	0.01	0.6%
Total Claims for Brand (Brand Rx)	5,123	5,952	(829.00)	-13.9%
Total Claims for Generic (Generic Rx)	36,895	35,707	1,188.00	3.3%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	631	658	(27.00)	-4.1%
Total Non-Specialty Claims	41,688	41,344	344.00	0.8%
Total Specialty Claims	330	315	15.00	4.8%
Generic % of Total Claims (GFR)	**87.8%**	**85.7%**	0.02	2.4%
Generic Effective Rate (GCR)	**98.3%**	**98.2%**	0.00	0.1%
Mail Order Claims	3,449	3,309	140.00	4.2%
Mail Penetration Rate*	9.1%	8.9%	0.00	0.2%

Claims Cost Summary			Claims Cost Summary	
Total Prescription Cost (Total Gross Cost)	$4,479,740.00	$4,110,635.00	$369,105.00	9.0%
Total Brand Gross Cost	$3,412,856.00	$3,131,632.00	$281,224.00	9.0%
Total Generic Gross Cost	$1,066,883.00	$979,003.00	$87,880.00	9.0%
Total MSB Gross Cost	$101,986.00	$109,153.00	($7,167.00)	-6.6%
Total Ingredient Cost	$4,463,414.00	$4,083,940.00	$379,474.00	9.3%
Total Dispensing Fee	$15,641.00	$26,192.00	($10,551.00)	-40.3%
Total Other (e.g. tax)	$685.00	$502.00	$183.00	36.5%
Avg Total Cost per Claim (Gross Cost/Rx)	**$106.61**	**$98.67**	$7.94	8.0%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$666.18	$526.15	$140.03	26.6%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$28.92	$27.42	$1.50	5.5%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$161.63	$165.89	($4.26)	-2.6%

Member Cost Summary			Member Cost Summary	
Total Member Cost	**$584,535.00**	**$696,669.00**	($112,134.00)	-16.1%
Total Copay	$584,535.00	$696,669.00	($112,134.00)	-16.1%
Total Deductible	$0.00	$0.00	$0.00	0.0%
Avg Copay per Claim (Copay/Rx)	$13.91	$16.72	($2.81)	-16.8%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$13.91**	**$16.72**	**($2.81)**	**-16.8%**
Avg Copay for Brand (Copay/Brand Rx)	$68.62	$78.60	($9.98)	-12.7%
Avg Copay for Generic (Copay/Generic Rx)	$6.32	$6.41	($0.09)	-1.4%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$25.21	$25.42	($0.21)	-0.8%
Net PMPM (Participant Cost PMPM)	**$22.90**	**$27.41**	($4.51)	-16.5%
Copay % of Total Prescription Cost (Member Cost Share %)	13.0%	16.9%	-3.9%	-23.0%

Plan Cost Summary			Plan Cost Summary	
Total Plan Cost (Plan Cost)	**$3,895,205.00**	**$3,413,966.00**	**$481,239.00**	**14.1%**
Total Specialty Drug Cost (Specialty Plan Cost)	$1,664,872.00	$1,258,909.00	$405,963.00	32.2%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$2,230,333.00	$2,155,057.00	$75,276.00	3.5%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$92.70**	**$81.95**	$10.75	13.1%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$597.57	$447.55	$150.02	33.5%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$22.60	$21.01	$1.59	7.6%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$136.42	$140.47	($4.05)	-2.9%
Net PMPM (Plan Cost PMPM)	**$152.59**	**$134.32**	**$18.27**	**13.6%**
PMPM for Specialty Only (Specialty PMPM)	$65.22	$49.53	$15.69	31.7%
PMPM without Specialty (Non-Specialty PMPM)	$87.37	$84.79	$2.58	3.0%

Quarterly Health Plan Performance Review
Prepared For PEBP

State of Nevada

Reporting Period:
07/2018 thru 03/2019 – Current Period
07/2017 thru 03/2018 – Prior Period

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

35+ years experience caring for Nevadans and their families

Member Centered Solutions

Access to Southwest Medical/OptumCare

Cost Structure & Network Strength

Local Service & Wellness Resources

On-Site Hospital Case Managers

Our Care Delivery Assets in Nevada

- ✓ 40 OptumCare locations and expanding
- ✓ Over 400 providers practicing evidence-based medicine
- ✓ 6 high acuity urgent cares
- ✓ Patient portal with e-visit capabilities
- ✓ Robust integrated EMR
- ✓ Access to schedule, renew script and view test results
- ✓ 4 MedExpress urgent care centers
- ✓ 7 convenient care walk-in locations
- ✓ 2 ambulatory surgery centers
- ✓ Brand new 55,000 sq ft state-of-the-art cancer center
- ✓ Saturday appointments with primary care

Enhancements Made for Your Members

- ✓ Adding new and more ways for your members to receive the care they need when they need it
- ✓ Expansion of specialty network in these areas: pulmonary, allergy, dermatology, general surgery, orthotics & prosthetic vendors
- ✓ Real Appeal weight loss program
- ✓ Dispatch Health to provide at home urgent visits
- ✓ 16 additional locations for physical therapy services
- ✓ P3 Primary Care with 9 locations added to network
- ✓ $0 telemedicine visits for your members
- ✓ Pilot on continuous glucose monitoring for diabetics to improve outcomes and management of medication

Key Performance Indicators

Demographics & Cost Data

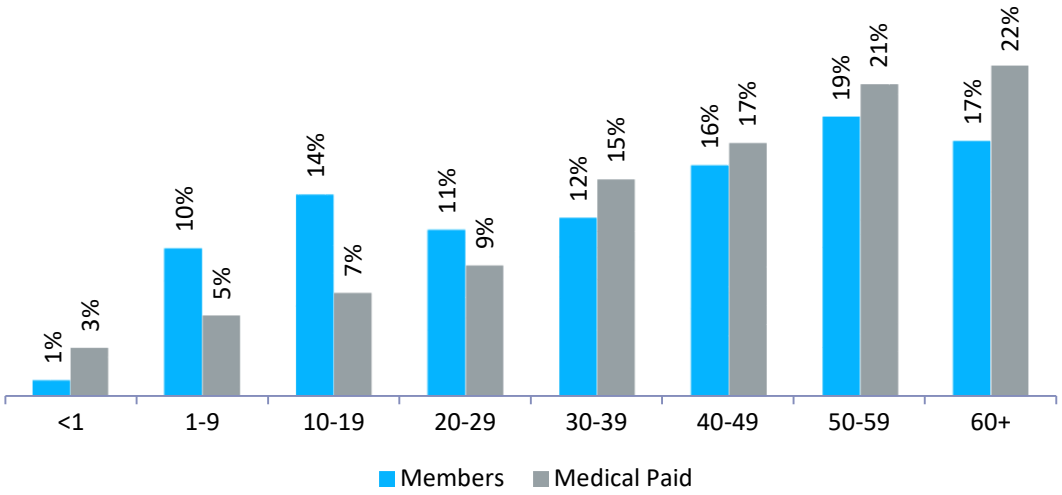
Data Definitions:

- **Prior Period** - July 1, 2017 through March 31, 2018
- **Current Period** - July 1, 2018 through March 31, 2019

Demographic Overview

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

	Prior	Current	Δ	Peer	Δ
Employees	3,980	3,888	-2.3%		
Average Age	49.6	49.4	-0.3%	44.2	11.8%
% Female	60.9%	61.6%	1.1%	50.1%	22.9%
Membership	6,814	6,705	-1.6%		
Average Age	38.3	37.9	-1.0%	35.0	8.2%
% Female	57.2%	56.9%	-0.5%	51.3%	10.9%
% Female (20 -44)	18.1%	18.4%	1.3%	21.2%	-13.4%
% Children (<18)	21.1%	21.7%	2.9%	21.6%	0.5%
% Dependents (18-25)	11.3%	11.3%	-0.1%	12.4%	-8.8%
Average Family Size	1.71	1.72	0.7%	1.81	-4.7%
Age Gender Factor	1.21	1.20	-0.6%	1.05	14.4%
HHS Population Risk Factor	1.73	1.53	-11.8%	1.20	27.4%



Population Insights

Membership decreased **-1.6%** to **6,705** covered under the medical plan for this period

Females are **56.9%** of membership driving **60.6%** of spend

Age 40+ are **51.8%** of members and drive **62.4%** of spend

HHS Risk Factor decreased **-11.8%** from prior period, but is still **27.4%** higher than Peer

Financial Highlights

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Financial

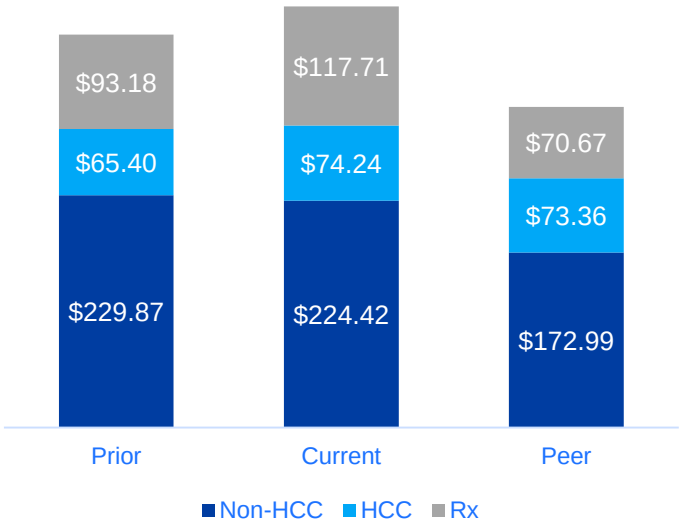
	Prior	Current	Δ		Peer	Δ
Net Paid PMPM	$295.22	$290.24	-1.7%	▼	$243.81	19.0%
Non-Catastrophic	$229.84	$230.77	0.4%		$175.31	31.6%
Catastrophic	$65.37	$59.47	-9.0%	▼	$68.50	-13.2%
Plan Cost Share	76.0%	71.2%	-6.3%		77.6%	-8.2%
Pharmacy PMPM	$93.18	$117.47	26.1%	▲	$70.53	66.5%

Catastrophic

Catastrophic Cases	39	35	-10.3%	▼		
% of Members	0.43%	0.40%	-8%		0.40%	0.0%
Average Net Paid	$106,307	$104,644	-1.6%		$121,115	-13.6%
% of Dollars as High Cost	17.4%	14.9%	-14.5%		22.7%	-34.4%

Trends Period over Period

- Medical PMPM Trend: **-1.7 %**
- Rx PMPM Trend: **26.1%**
- Combined PMPM trend: **5.0%**



Emergent/Urgent Services

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

	Prior	Current	Change	Peer	Δ
ER Visits	622	559	-10.0%		
ER Net Paid / Visit	$2,662	$2,718	2.1%	$2,462	10.4%
ER Visits per K	91	83	-8.6%	68	22.6%
UC Visits	3,347	3,545	5.9%		
UC Net Paid / Visit	$92	$96	4.2%	$92	4.1%
UC Visits per K	491	529	7.6%	412	28.3%

ER and Urgent Care Overview

- Number of free-standing emergency rooms growing in Nevada
- ER per 1000 utilization is lower in current period by **-8.6%**
- Higher use of urgent cares
- Urgent care average cost under $100 compared to ER visit of $2,700

Top 10 ER Diagnosis by Spend	ER Visits
Abdominal Pain	38
Nonspecific Chest Pain	33
Other Complications Of Pregnancy	21
Spondylosis; Intervertebral Disc Disorders	21
Dizziness Or Vertigo	14
Superficial Injury; Contusion	25
Biliary Tract Disease	9
Other Connective Tissue Disease	16
Cardiac Dysrhythmias	12
Headache; Including Migraine	17

On-Demand Care Services

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

ADVICE NURSE for care guidance, treatment alternatives and options

24/7

VIRTUAL VISITS through NowClinic to see a provider from any location

Advice Nurse Utilization

Prior	Current
558	564

NowClinic Visits

Prior	Current
362	268

Top Outcomes of Advice Nurse Call	Prior	Current
Sent to Urgent Care	205	194
Scheduled Appointment with Provider	102	112
Sent to Emergency Room	71	73
Provided Self-Care Options	71	73
Information or Advice Only	38	34
Call 911	15	13

High Cost Claimant (HCC) Data

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Overview of High Cost Claimants

HCC Summary	Prior	Current	Change	Peer	Δ
High Cost Members (>= $50,000)	39	35	-10.3%		
HCC's per 1,000	4.31	3.95	-8.2%	3.95	0.0%
% of Members as High Cost	0.43%	0.40%	-8.2%	0.40%	0.0%
% of Dollars as High Cost	17.4%	14.9%	-14.5%	22.7%	-34.4%
HHS Risk Score	33.45	23.49	-29.8%	27.18	-13.6%
High Cost Claimant Average Cost	**$106,307**	**$104,644**	**-1.6%**	**$121,115**	**-13.6%**
High Cost Claimant Average Med Cost	$102,789	$102,527	-0.3%	$116,329	-11.9%
High Cost Claimant Average Rx Cost	$3,518	$2,117	-39.8%	$4,785	-55.8%

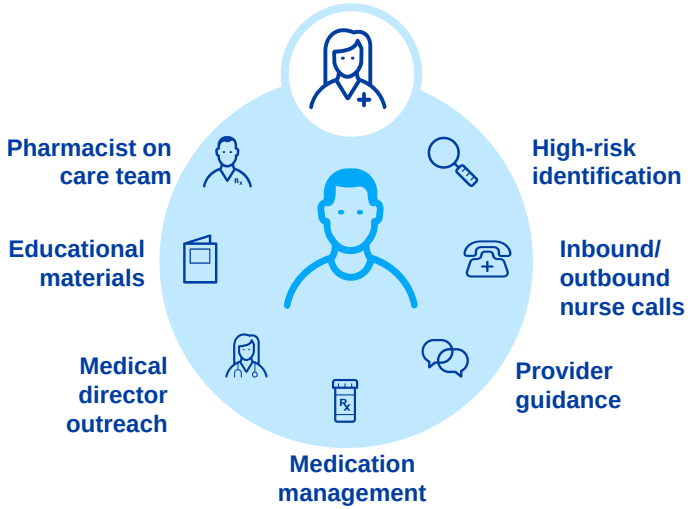
- Defined as $50,000+ in spend during measurement period
- High cost claimant paid dollars accounts for **14.9%** of total medical spend in the current period
- Lower number of claimants in current period
- Average cost per claimant increased in decreased by **-1.6%**

High Cost Claimant (HCC) Details

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Largest 10 Cases by Paid in Current Period

Case #	AHRQ Category Condition	Relation	Paid	Eligible
1	Rehabilitation care; fitting of prostheses; and adjustment of devices	Subscriber	$265,215.38	YES
2	Acute myocardial infarction	Subscriber	$242,301.77	YES
3	Complication of device; implant or graft	Spouse	$226,937.24	YES
4	Normal pregnancy and/or delivery	Dependent	$201,919.72	YES
5	Heart valve disorders	Spouse	$199,626.24	YES
6	Other nutritional; endocrine; and metabolic disorders	Spouse	$154,104.61	YES
7	Cancer of pancreas	Subscriber	$142,530.70	YES
8	Coagulation and hemorrhagic disorders	Subscriber	$134,253.14	YES
9	Cancer of ovary	Subscriber	$128,062.90	NO
10	Fracture of lower limb	Subscriber	$127,760.16	YES



- Care management team engagement
- 9 of the 10 high cost claimants are currently eligible
- Largest claimant is under $300,000
- Medical management works to ensure services are medically necessary and received at the appropriate level

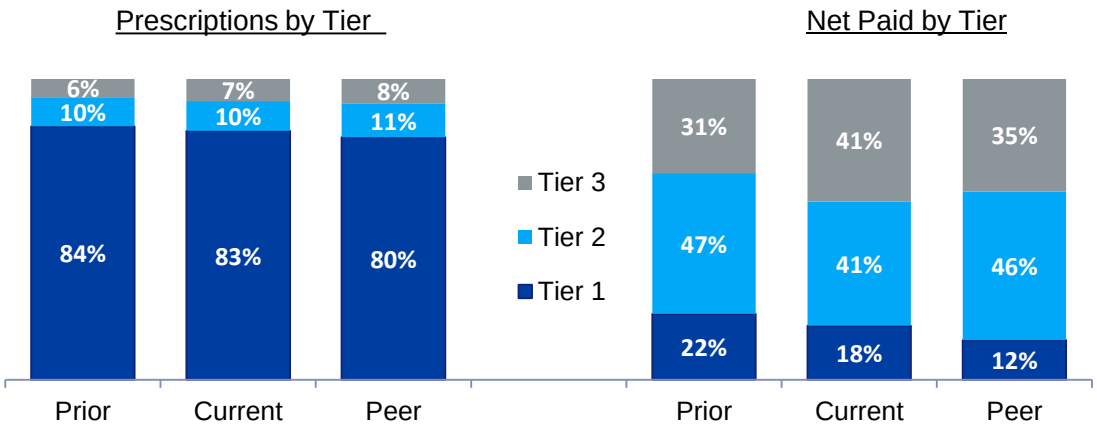
Pharmacy Data

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

	Prior	Current	Change	Peer	Δ
Enrolled Members	6,814	6,705	-1.6%		
Average Prescriptions PMPY	17.5	17.6	0.1%	10.6	65.0%
Formulary Rate	94.4%	93.2%	-1.3%	91.8%	1.5%
Generic Use Rate	88.1%	87.3%	-0.9%	87.0%	0.3%
Generic Substitution Rate	97.3%	97.4%	0.1%	96.4%	1.1%
Employee Cost Share PMPM	$25.49	$19.42	-23.8%	$12.47	55.8%
Avg Net Paid per Prescription	$63.77	$80.31	25.9%	$79.56	1.0%
Net Paid PMPM	$93.18	$117.47	26.1%	$70.53	66.5%

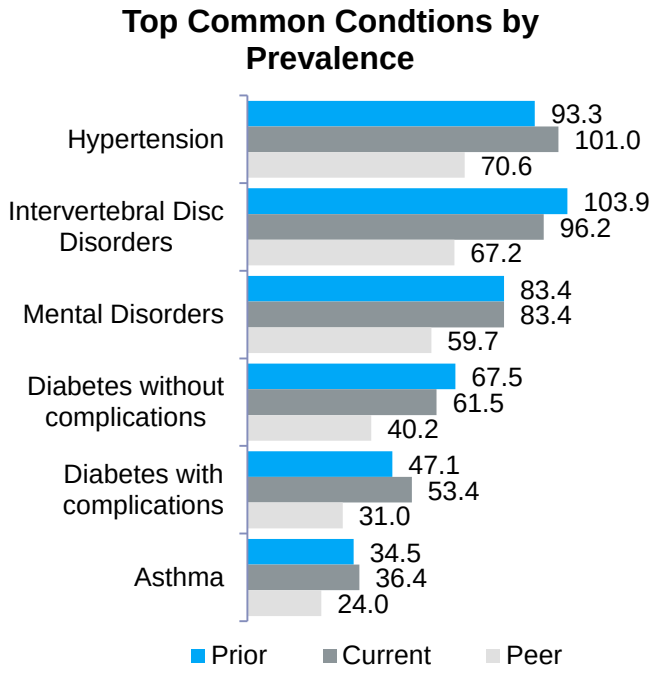
Pharmacy PMPM trend is 26.1%

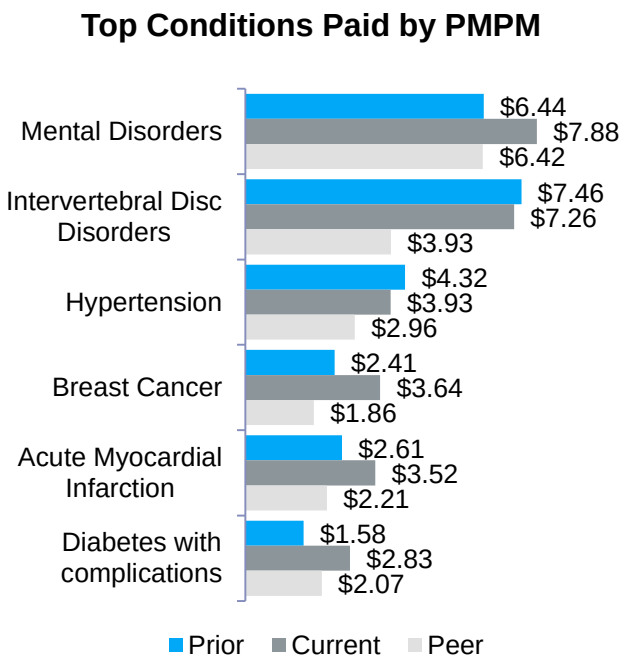
- Average net paid per script increased **25.9%**
- 83% of prescriptions were in Tier 1 and drove only **18.0%** of spend
- Tier 3 spend increased **30.0%** from prior period
- Cancer and Anti Diabetic Drugs driving spend



Common Diagnosis Categories

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company





- Hypertension, Intervertebral Disc Disorders and Mental Disorders are the most prevalent clinical conditions within the population.
- Prevalence of Hypertension increased **8.2%**, but spend decreased **-9.1%** on a PMPM basis from prior period
- Net paid for Mental Disorders increased **22.3%,** while prevalence remained flat
- **11.4%** of claimants have a diabetes diagnosis
- Chronic illnesses are driving the top common conditions

4.4.

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

   Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

   4.4. Receipt of quarterly vendor reports for the period ending March 31, 2019:

      4.4.1. HealthSCOPE Benefits – Obesity Care Management Program

      4.4.2. Hometown Health Providers – Utilization and Large Case Management

      4.4.3. The Standard Insurance – Basic Life and Long-Term Disability Insurance

      4.4.4. Towers Watson's One Exchange – Medicare Exchange

4.4.1.

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

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   4.4. Receipt of quarterly vendor reports for the period ending March 31, 2019:

      4.4.1. HealthSCOPE Benefits – Obesity Care Management Program

HSB DATASCOPE™

Obesity Care Management Report

Nevada Public Employees' Benefits Program

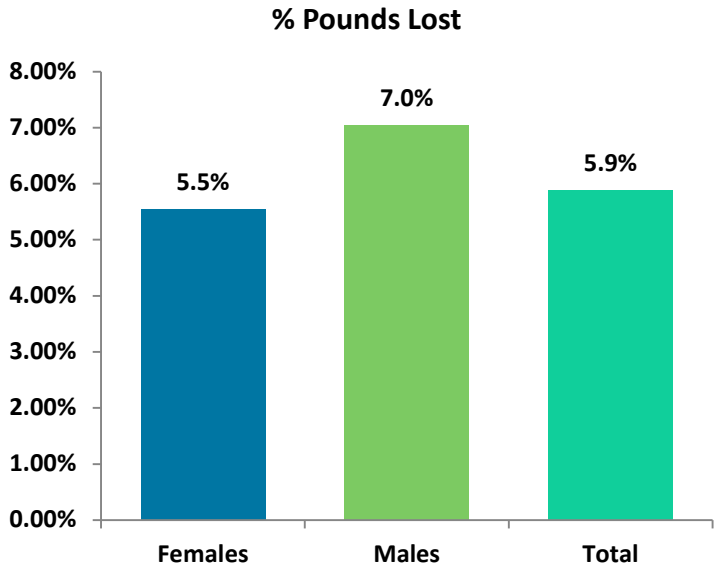
July 2018 – March 2019

HealthSCOPE BENEFITS

Obesity Care Management Overview

*Non-Participant is defined as a member who has been diagnosed with obesity in the past 12 months, but is not enrolled in the program

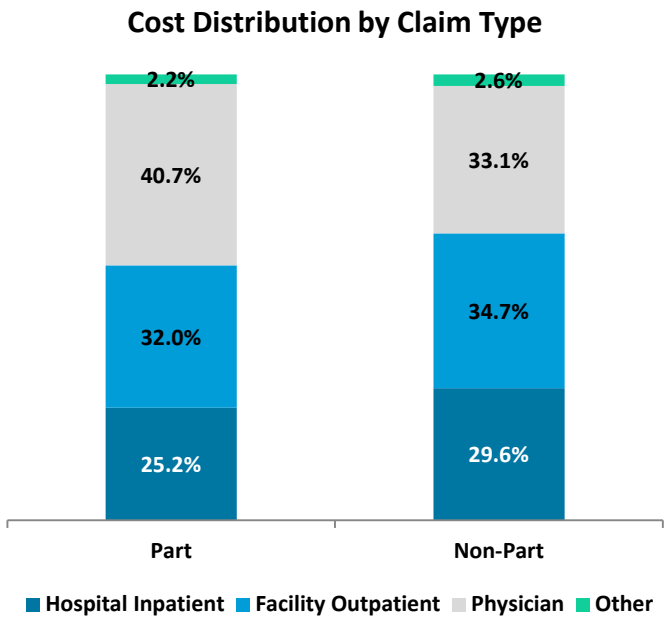
PEBP 3Q19			
Weight Management Summary	**Females**	**Males**	**Total**
# Mbrs Enrolled in Program	893	233	1,126
Average # Lbs. Lost	11.7	17.2	12.9
Total # Lbs. Lost	10,492.6	4,011.8	14,504.3
% Lbs. Lost	5.5%	7.0%	5.9%
Average Cost/ Member	$4,907	$4,053	$4,730



Obesity Care Management – Financial Summary

*Non-Participant is defined as a member who has been diagnosed with obesity in the past 12 months, but is not enrolled in the program

Summary	Participants	Non-Participants	Variance
Enrollment			
Avg # Employees	973	521	86.7%
Avg # Members	1,069	697	53.3%
Member/Employee Ratio	1.1	1.3	-17.9%
Financial Summary			
Gross Cost	$5,124,365	$4,363,046	
Client Paid	$3,958,974	$3,491,955	
Employee Paid	$1,165,391	$871,091	
Client Paid-PEPY	$5,423	$8,931	-39.3%
Client Paid-PMPY	$4,937	$6,677	-26.1%
Client Paid-PEPM	$452	$744	-39.2%
Client Paid-PMPM	$411	$556	-26.1%
High Cost Claimants (HCC's) > $100k			
# of HCC's	4	3	
HCC's / 1,000	3.7	4.3	0.0%
Avg HCC Paid	$141,326	$217,667	0.0%
HCC's % of Plan Paid	14.3%	18.7%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$1,245	$1,978	-37.1%
Facility Outpatient	$1,578	$2,316	-31.9%
Physician	$2,007	$2,207	-9.1%
Other	$108	$175	-38.3%
Total	$4,937	$6,677	-26.1%
	Annualized	Annualized	



Obesity Care Management – Utilization Summary

*Non-Participant is defined as a member who has been diagnosed with obesity in the past 12 months, but is not enrolled in the program

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	67	46	
# of Bed Days	287	278	
Paid Per Admit	$14,364	$22,366	-35.8%
Paid Per Day	$3,353	$3,701	-9.4%
Admits Per 1,000	84	88	-4.5%
Days Per 1,000	358	532	-32.7%
Avg LOS	4.3	6	-28.3%
Physician Office			
OV Utilization per Member	9.5	7.8	21.8%
Avg Paid per OV	$78	$56	39.3%
Avg OV Paid per Member	$740	$438	68.9%
DX&L Utilization per Member	14.4	17.8	-19.1%
Avg Paid per DX&L	$67	$62	8.1%
Avg DX&L Paid per Member	$963	$1,099	-12.4%
Emergency Room			
# of Visits	225	182	
# of Admits	37	33	
Visits Per Member	0.28	0.35	-20.0%
Visits Per 1,000	281	348	-19.3%
Avg Paid per Visit	$2,223	$2,447	-9.2%
Admits Per Visit	0.16	0.18	-11.1%
Urgent Care			
# of Visits	377	232	
Visits Per Member	0.47	0.44	6.8%
Visits Per 1,000	470	444	5.9%
Avg Paid per Visit	$44	$80	-45.0%
	Annualized	Annualized	

4.4.2.

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

   Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

   4.4. Receipt of quarterly vendor reports for the period ending March 31, 2019:

      4.4.2. Hometown Health Providers – Utilization and Large Case Management

Hometown Health

Quarterly Update for CDHP PPO PLAN Q3 FY 2019 (01/01/2019 - 03/31/2019)

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

Report Table of Contents

Case Management – Executive Summary

Case management (CM) is a voluntary process where the clinical professionals at the utilization management company work with patients and their family members, caregivers and other health care providers to assist with coordination of various medical treatment needs of patients. Case management services are particularly helpful when a plan participant (patient) needs complex, costly and/or high-technology services such as those related to organ and tissue transplants, certain cancer treatments, serious head injuries, hospice care or certain behavioral health issues.

Active Cases: For Q3 2019, 771 clients were identified through prior authorization and referral processes for screening by staff. Of those, 243 members met preliminary criteria for enrollment into the Case Management (CM) program and 208 accepted, representing 85.5% of eligible cases screened. Cases are identified from pre-certifications as well as potential high cost and trigger diagnosis reports.

	Screened	Eligible	Enrolled	%
Current Quarter 01/01/2019 – 3/31/2019	771	243	208	85.5%
Previous Quarters 10/01/2018 to 12/31/2018	645	118	91	77.1%
Screened Plan Year 2019 07/01/2018 to 3/31/2019	2112	452	363	80.3%

For the current quarter, of the 771 clients screened:

- 565 discharged patients were managed and transitioned through case management to alternate levels of care or discharged home on an independent basis. 208 cases were actually managed in the post-discharge setting.

- 243 members met preliminary criteria for enrollment into CM. 208 members elected to participate in the CM program. 35 members were not enrolled due to various factors related to lack of MD referrals, end of life issues, declined consents, and other social behavior influences.

- In addition to 208 new cases, 192 extended cases were carried over from previous monitoring periods, bringing total enrollment for the quarter to 400 with typical case duration of 9 months to 2 years as members regain function and stabilize or their condition deteriorates.

Case Management – Executive Summary (continued)

The majority of clients referred to CM continues to be from the Utilization Review nurses at time of referral, time of hospital admission, or time of transition to an alternate level of care. These referrals make up 75% of the referrals to Case Management. 25% of the cases screened came from physicians, plan referrals, specialty clinics and other health care facilities.

Case management estimated cost savings is $1,176,239 for the third quarter of Plan Year 2019. Additional savings will be realized under Healthscope for the early intervention and referrals/resources channeled to in-network provider services.

Conclusion

During the third quarter of Plan Year 2019, 771 unique members were screened for possible case management intervention. Of the 771, 243 members met preliminary criteria for enrollment into CM and 208 members (85.5%) elected to enroll in the program.

Case Management – Referral Reason Report

	Quarterly 1/1/2019 to 3/31/2019	Year to Date 7/1/2018 to 3/31/2019
CM Trigger List	771	2112
High Dollar	Included in Trigger List	Included in Trigger List
High Risk	Included in Trigger List	Included in Trigger List
Other		
Totals	**771**	**2112**

Case Type – Summary Report

	Quarterly 1/1/2019 to 3/31/2019					Year to Date 07/01/2018 to 3/31/2019				
	New Cases Opened	Full Cases Opened	Benefit Mgmt	LOAs	Totals	New Cases Opened	Full Cases Opened	Benefit Mgmt	LOAs	Totals
Bariatric	10	42	4		**56**	28	96	56		**180**
LCM	156	283	98		**537**	272	472	217		**961**
BH/CHEM	39	58	18		**115**	56	76	57		**189**
Transplant	3	17	2		**22**	7	49	101		**157**
Other										
Totals	**208**	**400**	**122**	**0**	**730**	**363**	**693**	**431**	**17**	**1487**

Total Open Cases	**198**

Case Management – Summary Report

Report Glossary:

New Cases Opened:
Number of cases opened to full (traditional) case management within the period.

Full Cases Opened
Number of existing cases carried over from previous reporting periods remaining active during current reporting period. (Excludes new cases opened within period).

Benefit Management Cases:
Referrals for simple discharge planning, resources, brief education, CM consults, etc. within the period.

LOAs
Extra-contractual agreements executed within the period.

Case Management – Saving Detail for Open & Closed Cases (Continued)

1/1/2019 to 3/31/2019						
Case Type	**Care Level Status**	**Vendor Negotiations**	**Averted Adm Savings**	**Change in Level of Care**	**Proposed Alternative Plan**	**Total Savings**
LCM	Active			$ 22,800		$ 22,800
LCM	Active			$ 8,000		$ 8,000
LCM	Active		$ 51,220			$ 51,220
LCM	Active		$ 9,250			$ 9,250
LCM	Active			$ 14,200		$ 14,200
LCM	Active			$ 1,200		$ 1,200
LCM	Active		$ 5,832			$ 5,832
LCM	Active			$ 32,200		$ 32,200
LCM	Active			$ 8,400		$ 8,400
LCM	Active			$ 8,800		$ 8,800
LCM	Active		$ 18,000			$ 18,000
LCM	Active		$ 47,446			$ 47,446
LCM	Active			$16,800		$ 16,800
LCM	Active			$ 37,800		$ 37,800
LCM	Active		$ 57,400	$ 8,000		$ 65,400

Case Management – Saving Detail for Open & Closed Cases (Continued)

1/1/2019 to 3/31/2019						
Case Type	**Care Level Status**	**Vendor Negotiations**	**Averted Adm Savings**	**Change in Level of Care**	**Proposed Alternative Plan**	**Total Savings**
LCM	Active			$ 3,000		$ 3,000
LCM	Active		$ 22,200			$ 22,200
LCM	Active			$ 60,200		$ 60,200
LCM	Active		$ 25,317			$ 25,317
LCM	Active			$ 4,512		$ 4,512
LCM	Active			$ 99,400		$ 99,400
LCM	Active			$ 40,800		$ 40,800
LCM	Active		$ 65,353	$ 2,200		$ 67,553
LCM	Active		$ 16,100	$ 8,400		$ 16,100
LCM	Active		$ 57,633			$ 57,633
LCM	Active			$ 22,400		$ 22,400
LCM	Active			$ 2,400		$ 2,400
LCM	Active			$11,200		$ 11,200
LCM	Active			$ 396		$ 396
LCM	Active			$ 12,600		$ 12,600

Case Management – Saving Detail for Open & Closed Cases (Continued)

1/1/2019 to 3/31/2019						
Case Type	**Care Level Status**	**Vendor Negotiations**	**Averted Adm Savings**	**Change in Level of Care**	**Proposed Alternative Plan**	**Total Savings**
LCM	Active			$ 2,000		$ 2,000
LCM	Active			$ 22,400		$ 22,400
LCM	Active			$ 17,600		$ 17,600
LCM	Active			$ 14,400		$ 14,400
LCM	Active		$ 1,900			$ 1,900
LCM	Active			$ 10,400		$ 10,400
LCM	Active		$ 6,343	$ 1,600		$ 22,343
LCM	Active			$ 24,975		$ 24,975
LCM	Active		$ 6,795			$ 6,795
LCM	Active		$ 57,040			$ 57,040
LCM	Active		$ 103,040			$ 103,040
LCM	Active			$ 51,000		$ 51,000
LCM	Active			$8,400		$ 8,400
BH/CHEM	Active			$ 4,750		$ 4,750
BH/CHEM	Active			$ 14,550		$ 14,550

Case Management – Saving Detail for Open & Closed Cases (Continued)

1/1/2019 to 3/31/2019						
Case Type	**Care Level Status**	**Vendor Negotiations**	**Averted Adm Savings**	**Change in Level of Care**	**Proposed Alternative Plan**	**Total Savings**
BH/CHEM	Active		$ 1,282	$ 4,620		$ 5,902
BH/CHEM	Active		$ 2,294			$ 2,294
BH/CHEM	Active		$ 690			$ 690
BH/CHEM	Active			$ 750		$ 750
BH/CHEM	Active		$ 5,452			$ 5,452
BH/CHEM	Active		$ 4,174			$ 4,174
BH/CHEM	Active		$ 480			$ 480
BH/CHEM	Active			$ 1,250		$ 1,250
BH/CHEM	Active			$ 21,000		$ 21,000
BH/CHEM	Active			$ 9,240		$ 9,240
BH/CHEM	Active		$ 1,480			$ 1,480
BH/CHEM	Active		$ 1,540			$ 1,540
BH/CHEM	Active			$4,500		$ 4,500
BH/CHEM	Active			$ 29,400		$ 29,400
BH/CHEM	Active			$ 4,290		$ 4,290

Case Management – Saving Detail for Open & Closed Cases (Continued)

1/1/19 to 3/31/19						
Case Type	**Care Level Status**	**Vendor Negotiations**	**Averted Adm Savings**	**Change in Level of Care**	**Proposed Alternative Plan**	**Total Savings**
BH/CHEM	Active			$ 5,610		$ 5,610
BH/CHEM	Active			$ 5,250		$ 5,250
Quarterly Savings by Type			$568,261	$607,978		
Total Quarterly Savings Q3 2019						$1,176,239
Q1 + Q2 +3 2019 Savings						$3,047,648
Year To Date ROI						$3,047,648

Utilization Management – Executive Summary

The PEBP Consumer Driven Health Plan (CDHP) requires participants to obtain a pre-certification for certain medical services such as inpatient hospital admissions, skilled nursing facility admissions and bariatric weight loss surgeries. This requirement is also referred to as utilization management, utilization review, concurrent and retrospective review. The purpose of utilization management is to evaluate the appropriateness, the medical need and efficiency of certain healthcare services and procedures.

Inpatient Utilization Overview:

Based on the first quarter, the PEBP population was 43,014 (average monthly lives for the quarter). Third quarter data shows 584 member admissions and 565 member discharges. Discharges for the third quarter were 13.40 members per thousand lives managed. Discharges annualized were 53.57 members per thousand lives managed. Bed days for the third quarter were 67.65 members per thousand lives managed. Bed days annualized were 270.41 members per thousand lives managed. The average length of stay was 5.07 days.

Inpatient Authorization and Denials:

The data show 565 authorized admissions were discharged in the quarter. General Med/Surg discharges composed the majority of all discharges with 430 (76%), Mother and Newborn 67 (12%), Mental Health 42 (7%), Skilled Nursing 12 (2%), Rehab 7 (1%), NICU 3 (1%), and Transplants 1 (1%) total discharges.

Quarter/Year	General Med/Surg	Mother & Newborn	Mental Health	Skilled Nursing	Rehab	NICU	Transplants
3Q 2019	430 76%	67 12%	42 7%	12 2%	7 1%	3 1%	1 1%

First quarter data shows 8 admission denials for a total of 21 denial days. All 8 admit(s) with 21 day(s) were "*DENIED NOT COVERED BY PLAN*".

Utilization Management – Executive Summary (Continued)

Reviewing Discharges by Specialty for the this Quarter:

- **General Med/Surg** discharges were 430, with a total of 1,675 authorized days and an average LOS of 3.90 days. Bed days of 39.70 per thousand lives managed for the quarter *(annualized 158.69 per thousand),* and10.21 members discharged per thousand of lives managed for the quarter *(annualized 40.83 per thousand).*

- **Mother & Newborn** discharges were 67, with a total of 154 authorized days and an average LOS of 2.30 days. Bed days of 3.68 per thousand lives managed for the quarter *(annualized 14.70 per thousand)* and 1.60 members were discharged per thousand lives managed for the quarter *(annualized 6.36 per thousand).*

- **Mental Health** discharges were 42, with a total of 287 authorized days and an average LOS of 6.83 days. Bed days of 6.70 per thousand lives managed for the quarter *(annualized 26.76 per thousand)* and 0.98 members were discharged per thousand lives managed for the quarter *(annualized 3.92 per thousand).*

- **Skilled Nursing** discharges were 10, with a total of 207 authorized days and an average LOS of 20.7 days. Bed days of 4.98 per thousand lives managed for the quarter *(annualized 19.92 per thousand)* and 0.24 members were discharged per thousand lives managed for the quarter *(annualized 0.95 per thousand).*

- **Rehab** discharges were 7, with a total of 164 authorized days and an average LOS of 23.42 days. Bed days of 3.84 per thousand lives managed for the quarter *(annualized 15.34 per thousand)* and 0.17 members were discharged per thousand lives managed for the quarter *(annualized 0.67 per thousand).*

- **NICU** discharges were 6, with a total of 68 authorized days and an average LOS of 11.33 days. Bed days of 1.58 per thousand lives managed for the quarter *(annualized 6.32 per thousand)* and 0.14 members were discharged per thousand lives managed for the quarter *(annualized 0.57 per thousand).*

- **Transplants** discharges were 3, with a total of 22 authorized days and an average LOS of 7.33 days. Bed days of 0.78 per thousand lives managed for the quarter *(annualized 3.11 per thousand)* and 0.11 members were discharged per thousand lives managed for the quarter *(annualized 0.42 per thousand).*

Utilization Management – Executive Summary (Continued)

Age and Gender Distribution:
Third quarter discharges show 28.8% of the members discharged fall in the age bracket of 50-64. Overall women make-up 60.53% of all discharges in this quarter.

Out-Patient Utilization and Denials *(Services Include: Outpatient Surgical Services, Durable Medical Equipment, Medical Office Visits, Infusion Services (equipment and supplies), Ambulatory Services, Mental health and Substance Abuse (Partial Hospital), Outpatient Mental Health Services, Medical Transportation, Dialysis Services, Wound Care Services, Outpatient Transplant Services, Prenatal Care, Home Health)***:**

Third quarter outpatient utilization consisted of 1,615 requests for services authorized. Authorizations for services are as follows: Outpatient Surgical Services composed 66.19% of total requests. Durable Medical Equipment composed 11.27% of total requests. Medical Office Services requests composed 10.71% of total requests. Infusion Services composed 5.20% and Ambulatory Services composed 4.40% of total request. The remaining requests composed 2.24% of total requests and include: Mental health and Substance Abuse (Partial Hospital), Medical Transportation, Prenatal Care, Outpatient Transplant Services, Outpatient Mental Health Services, Dialysis Services, Outpatient Rehabilitative Therapy Services, & Obstetrical (0.87%, 0.31%, 0.31%, 0.19%, 0.19%, 0.19%, 0.12%, and 0.06% respectively).

There were 20 outpatient requests for services denied during this quarter of FY 2019. The requests included 3 for ***Outpatient Surgical Services,*** 2 for ***Durable Medical Equipment (DME),*** 2 for ***Medical Office Services,*** and 2 for ***Ambulatory Services*** were denied as "Not Covered by Plan". 8 for ***Durable Medical Equipment (DME)*** *and* 1 for ***Ambulatory Services*** were "Denied Not Medically Necessary". 2 for ***Ambulatory Services*** were denied as "Experimental Services EXC

Estimated savings provided do not include denials of coverage for services designated as non covered in the PEBP Master Plan document or potential savings from Letters of Agreement negotiated by Hometown health, but administered by PEBP and Healthscope.

Inpatient Utilization

3rd Quarter Plan Year 2019 01/01/2019 - 03/31/2019			
Average Population	**43,014**	Quarterly Discharges Per Thousand	**13.44**
Total Discharges	**565**	Quarterly Bed Days Per Thousand	**53.72**
Days Approved	**2,577**		
Total Reviews Performed			
Admissions	**584**		
Concurrent	**360**		
Retrospective	**224**		

*The above table provides an overview of inpatient pre-certification/authorizations.

Inpatient Authorizations & Denials

3rd Quarter Plan Year 2019 01/01/2019 - 03/31/2019 Admissions	Total	General Med/Surg	Mother & Newborn	Mental Health	Rehab	Skilled Nusing	NICU	Trasnsplants
# of Discharges	514	430	67	42	7	10	6	3
Quarterly Discharges per 1000	13.44	10.21	1.59	0.98	0.17	0.24	0.14	0.11

Total Denied Denials	Surgical	Medical	Detox	Obstetrical	Rehab	Skiilled Nursing	Observation	Total
Total Number of Denied Requests	1	1	0	5	0	0	1	8
Denied, Not Medically Necessary	0	0	0	0	0	0	0	0
Denied, Not Covered by Plan	1	1	0	5	0	0	1	8
Denied, Member Exceeds Max Limits	0	0	0	0	0	0	0	0

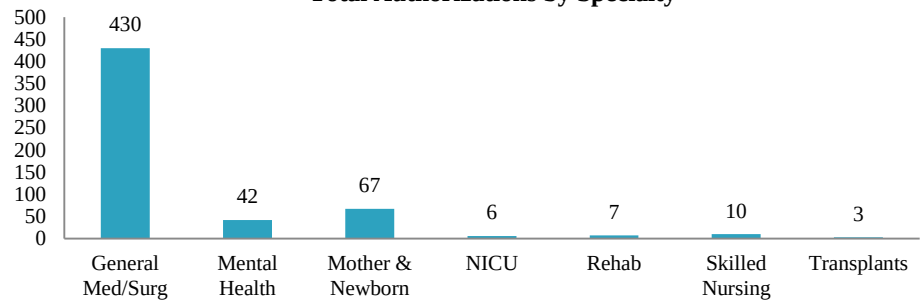
*The above tables provide an overview of inpatient authorization by utilization data. Total denied days are derived from prospective and concurrent reviews.

Inpatient Discharge Information

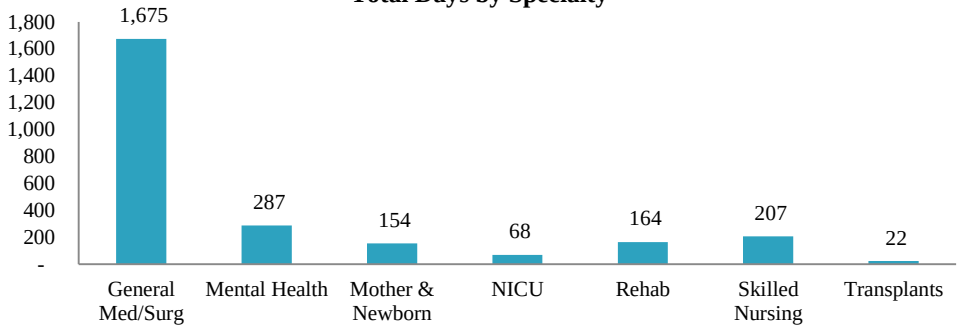
3rd Quarter Plan Year 2019 01/01/2018 - 03/31/2019					
Discharges by Specialty	Total Auths	Total Days	Average LOS	Quarterly Beddays/1,000	Quarterly Discharges/1,000
General Med/Surg	430	1,675	3.90	39.70	10.21
Mother & Newborn	42	287	6.83	6.70	0.98
Mental Health	67	154	2.30	3.68	1.59
Rehab	7	164	23.43	3.84	0.17
Skilled Nursing	10	207	20.70	4.98	0.28
NICU	6	68	11.33	1.58	0.14
Transplants	3	22	7.33	0.78	0.11

*The above tables provide an overview of discharges by category and as a whole, in addition the table provides a further breakout of the medical category. Graphic representation of Discharges by specialty is located on pages 17 through 18 of this report.

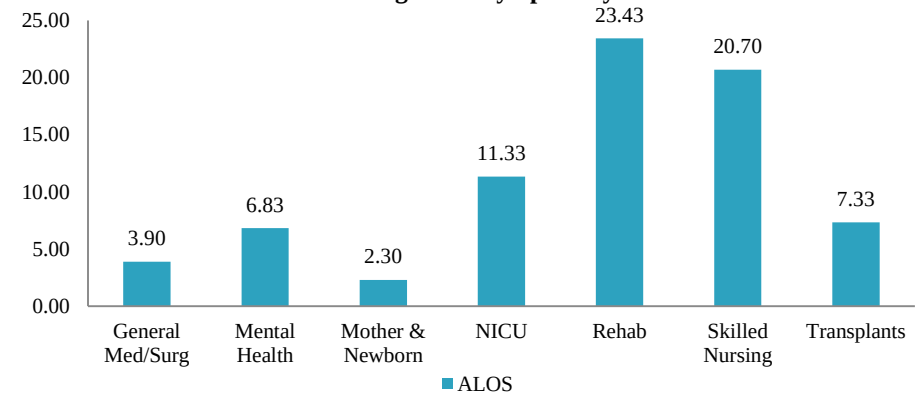
Total Authorizations by Specialty



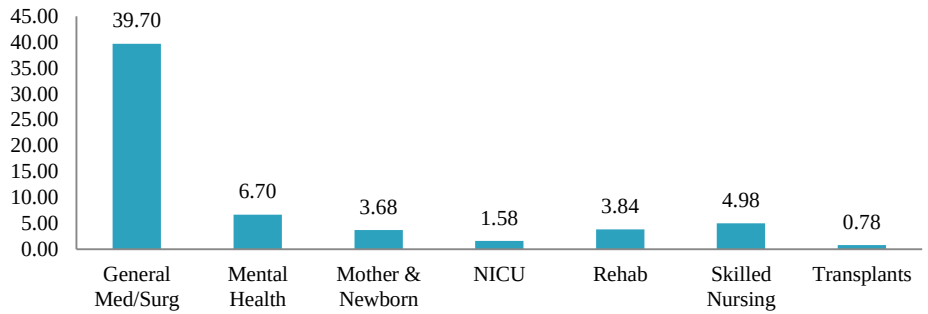
Total Days by Specialty



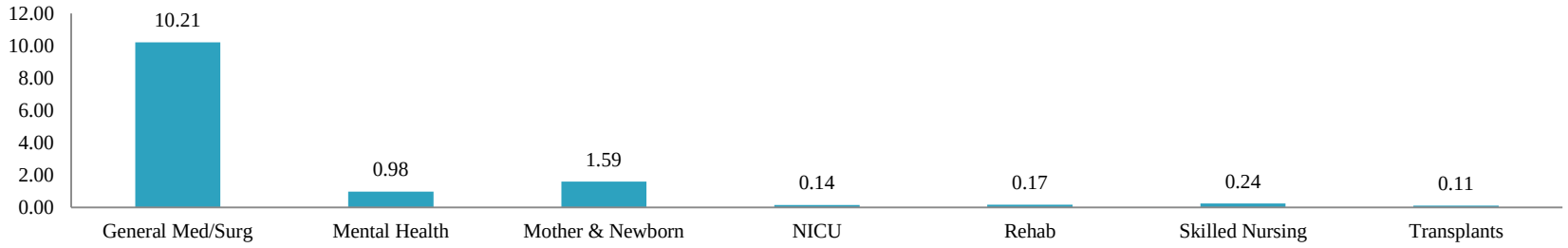
Average LOS by Specialty



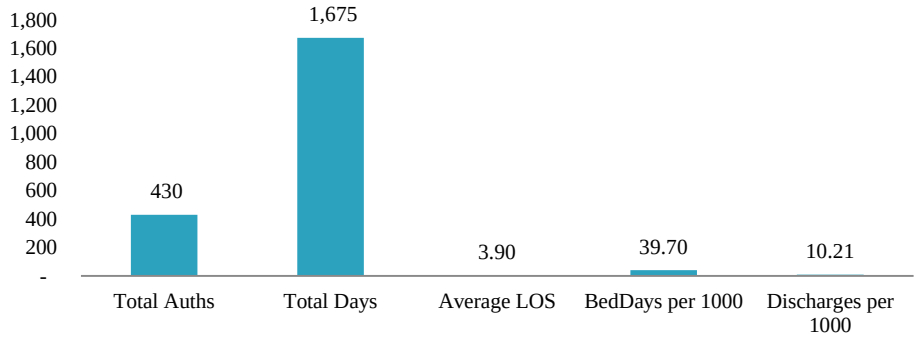
Average Bed Days per Thousand



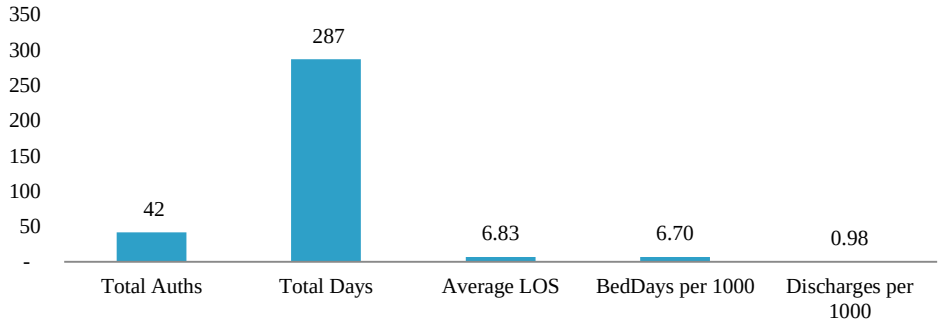
Discharges per Thousand



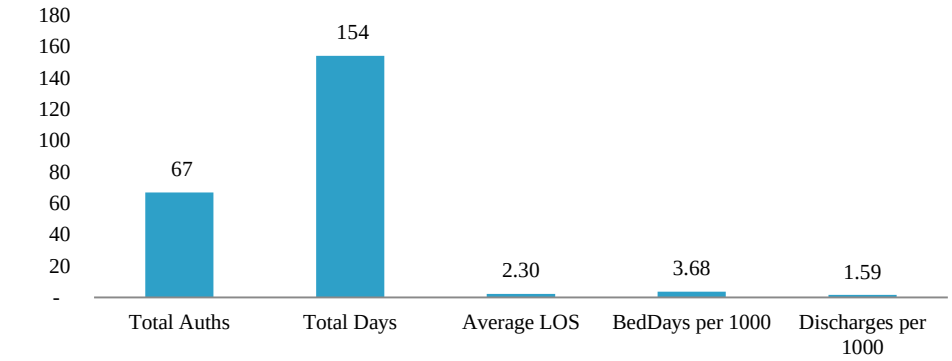
General Med/Surg



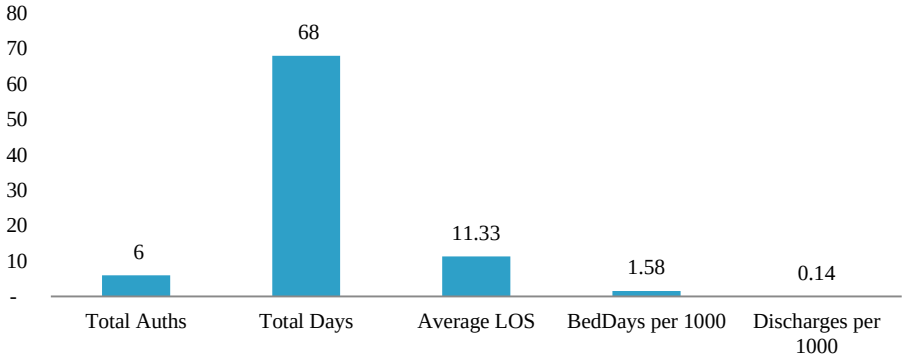
Mental Health



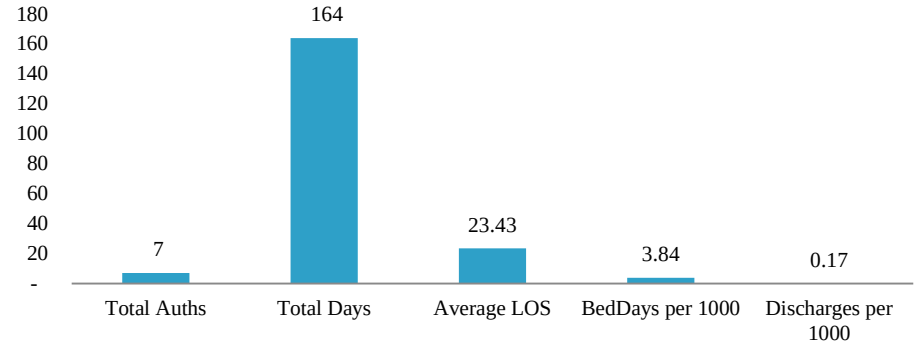
Mother & Newborn



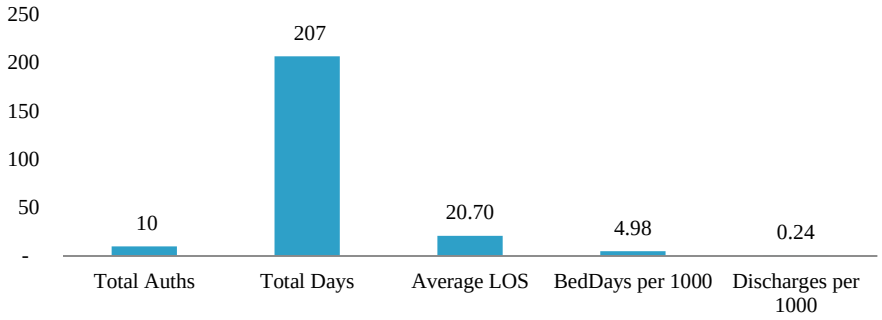
NICU



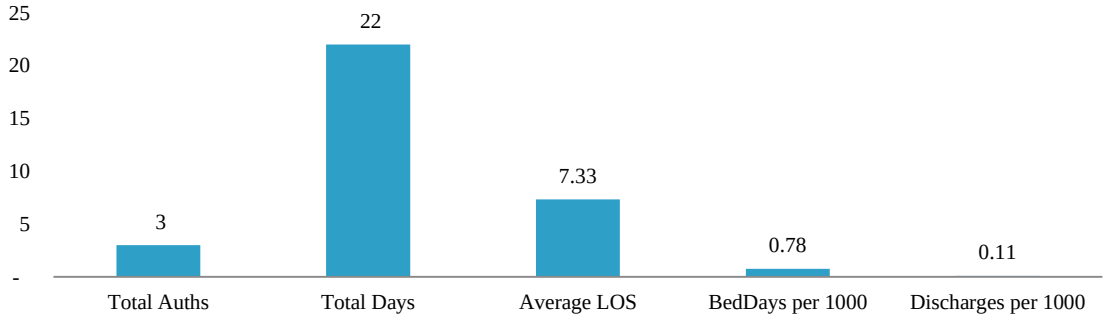
Rehab



Skilled Nursing

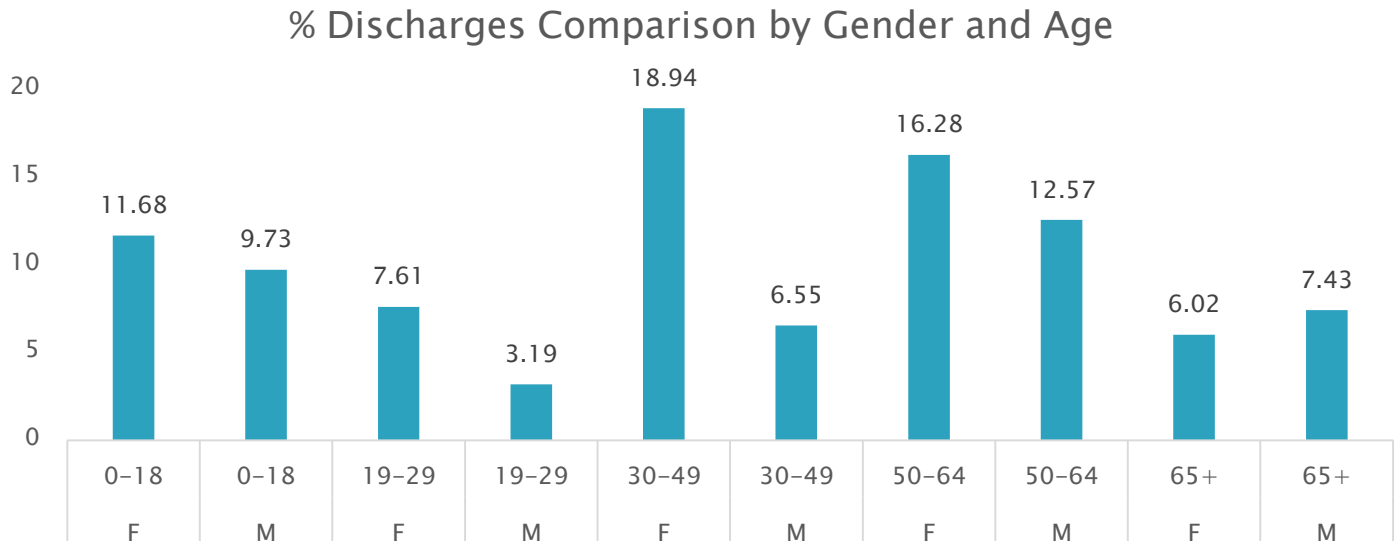


Transplants



Age & Gender Distribution

3rd Quarter Plan Year 2019 01/01/2019 - 03/31/2019 Age Categories	0 - 18	19 - 29	30 - 49	50 - 64	65+	Total
Female	66	43	107	92	34	342
Male	55	18	37	71	42	223
Total	**121**	**61**	**144**	**163**	**76**	**565**
Total (%)	**20**	**11**	**25**	**29**	**13**	**100**



*The above table provides a breakout of discharged members by age categories, the above graph provides a comparison of male to female discharges in the same age categories.

Outpatient Authorizations & Denials

3rd Quarter Plan Year 2019 01/01/2019 - 03/31/2019 Authorizations	
OUTPATIENT SURGICAL SERVICES	1069
DURABLE MEDICAL EQUIPMENT	182
MEDICAL OFFICE SERVICES	173
INFUSION SERVICES, EQUIPMENT AND SUPPLIES	84
AMBULATORY SERVICES	71
MENTAL HEALTH & SUBSTANCE ABUSE PARTIAL	14
MEDICAL TRANSPORTATION SERVICES	5
PRENATAL CARE SERVICES	5
OUTPATIENT TRANSPLANT SERVICES	3
OUTPATIENT MENTAL HEALTH SERVICES	3
DIALYSIS SERVICES	3
OUTPATIENT REHABILITATIVE THERAPY SERVICES	2
OBSTETRICAL	1
Totals	**1615**

Denials	Ambulatory Services	Outpatient	Medical Office Services	Infusion Services, Equipment & Supplies	DME	Prenatal Care	Mental Health & Substance Abuse	Total
Denied, Not Medically Necessary	1	0	0	0	8	0	0	9
Denied, Not Covered by Plan	2	2	2	1	2	0	0	9
Denied Experimental SVCS EXC	2	0	0	0	0	0	0	2
Total Number of Denied Requests	**1**	**0**	**0**	**0**	**8**	**0**	**0**	**20**

Appendix A

Medical Discharges by Facility and Level of Care

Facility	Total Admits	Total Days	Level Of Care	ALOS by Level of Care
ADVANCED HEALTH CAREOF LV	2	34	SNF	17.00
ADVENTHEALTH ORLANDO	1	3	Acute	3.00
BANNER CHURCHILL COMMUNITY HOSP	1	2	Acute	2.00
BARSTOW COMM HOSPITAL	1	1	Acute	1.00
BARTON MEMORIAL HOSPITAL	1	1	Acute	1.00
BOZEMAN HEALTH DEACONESS HOSPITAL	1	3	Acute	3.00
CALIFORNIA PACIFIC MEDICAL CENTER	1	4	Acute	4.00
CAREMERIDIAN	1	3	SNF	3.00
CAREMERIDIAN-CARMENBLVD	2	43	SNF	21.50
CARSON TAHOE BEHAVIORAL HLTH SVCS	8	75	Mental Health	9.38
CARSON TAHOE REGIONAL MEDICAL CTR	63	162	Acute	2.57
CARSON TAHOE REGIONAL MEDICAL CTR	1	3	Mental Health	3.00
CARSON TAHOE SIERRASURGERY	5	19	Acute	3.80
CARSON VALLEY MEDICAL CENTER	3	6	Acute	2.00
CENTENNIAL HILLS HOSPITAL MED CTR	37	90	Acute	2.43
COMPASS WHITE COUNTYMED CNTR	1	5	Mental Health	5.00
COMPLEX CARE HOSPITAL AT TENAYA	2	89	Acute	44.50
CORNERSTONE HOSPITALMED CENTER	1	15	Acute	15.00
CORONADO SURGERY CENTER	1	1	Acute	1.00
CROSSROADS OF SOUTHERN NEVADA	1	5	Mental Health	5.00
DAVIS MEMORIAL HOSPITAL	1	3	Acute	3.00
DESERT PARKWAY BEHAVIORAL HEALTH	1	7	Mental Health	7.00
DESERT SPRINGS HOSPITAL	10	48	Acute	4.80
DIAMOND HOUSE DETOX	2	13	Mental Health	6.50
DIXIE REGIONAL MED CENTER	1	3	Acute	3.00
ENCOMPASS REHAB HOSPOF HENDERSON	2	24	Rehab	12.00
ENLOE MEDICAL CENTER	2	10	Acute	5.00
GROVER C DILS MEDICAL CENTER	1	1	Acute	1.00
HENDERSON HOSPITAL	8	14	Acute	1.75
HUMBOLDT GENERAL HOSPITAL	1	1	Acute	1.00
JOHNSTON MEMORIAL HOSP	1	1	Acute	1.00
KINDRED HOSPITAL LASVEGAS SAHARA	1	11	Acute	11.00
KINDRED TRANS CARE AND REHAB	1	7	SNF	7.00
LAS VEGAS RECOVERY CENTER	1	3	Mental Health	3.00

Facility	Total Admits	Total Days	Level Of Care	ALOS by Level of Care
LOMA LINDA UNIVERSITY MEDICAL CENTE	2	18	Acute	9.00
LONG BEACH MEMORIALMEDICAL CTR	1	3	Acute	3.00
LOWER VALLEY HOSP ASN DBA FAMILY HE	1	8	Acute	8.00
MARSHALL HOSPITAL	1	11	Acute	11.00
MAYO CLINIC HOSPITAL	1	4	Acute	4.00
MAYO CLINIC HOSPITALROCHESTER	1	2	Acute	2.00
MIKE O'CALLAGHAN FEDHOSPITAL	1	3	Acute	3.00
MOUNTAIN VIEW HOSPITAL	20	57	Acute	2.85
MOUNTAIN VIEW HOSPITAL	1	11	Rehab	11.00
NORTH VISTA HOSPITAL	2	4	Acute	2.00
NORTHEASTERN NEV R/H	7	17	Acute	2.43
NORTHERN NV MEDICAL	3	18	Acute	6.00
OKLAHOMA STATE UNIVMEDICAL CENTER	1	4	Acute	4.00
ORMSBY POST ACUTE REHAB	3	110	SNF	36.67
OROVILLE HOSPITAL	1	2	Acute	2.00
PARKVIEW MEDICAL CENTER	1	2	Acute	2.00
PINE REST CHRISTIANMENTAL HEALTH	1	11	Mental Health	11.00
RENO BEHAVIORAL HEALTHCARE HOSP	1	8	Acute	8.00
RENO BEHAVIORAL HEALTHCARE HOSP	2	19	Mental Health	9.50
RENOWN REGIONAL MEDICAL CENTER	119	389	Acute	3.27
RENOWN REHAB HOSPITAL	2	79	Rehab	39.50
RENOWN SOUTH MEADOWS	24	52	Acute	2.17
RONALD REAGAN UCLA MEDICAL CENTER	3	9	Acute	3.00
SANTA BARBARA COTTAGE HOSPITAL	1	4	Acute	4.00
SERENITY OAKS WELLNESS CENTER	1	1	Mental Health	1.00
SEVEN HILLS BEHAVIORAL INSTITUTE	6	36	Mental Health	6.00
SOUTHERN HILLS HOSPITAL	10	24	Acute	2.40
SPARKS MEDICAL CENTER VAN BUREN	1	3	Acute	3.00
SPRING MOUNTAIN TREATMENT CENTER	6	36	Mental Health	6.00
SPRING VALLEY HOSPITAL MEDICAL CTR	14	53	Acute	3.79
ST JOSEPH MEDICALCENTER	1	8	Acute	8.00
ST LUKES COMMUNITY MEDICAL CENTER	1	4	Mental Health	4.00

Facility	Total Admits	Total Days	Level Of Care	ALOS by Level of Care
ST MARYS HOSP & MEDCTR - CO	1	4	Acute	4.00
ST MARYS REGIONAL MED CTR	4	15	Acute	3.75
ST ROSE DOMINICAN HOSPITAL - DELIMA	1	1	Acute	1.00
ST ROSE DOMINICAN SAN MARTIN CAMPUS	9	33	Acute	3.67
ST ROSE DOMINICAN SIENA	32	134	Acute	4.19
STANFORD MEDICAL CENTER	1	4	Acute	4.00
SUMMERLIN HOSPITAL MEDICAL CENTER	38	121	Acute	3.18
SUNRISE HOSPITAL & MEDICAL CTR	12	30	Acute	2.50
TAHOE PACIFIC HOSPITAL	1	6	Acute	6.00
THE DESERT HOPE TREATMENT CENTER	3	18	Mental Health	6.00
THE METHODIST HOSPITAL	2	7	Acute	3.50
THE PROVIDENCE TRANSMOUNTAIN CAMPUS	1	2	Acute	2.00
TUCSON MEDICAL CENTER	1	11	Acute	11.00
U OF U HOSPITAL CLINICS	5	27	Acute	5.40
U OF U HOSPITAL CLINICS	1	22	Rehab	22.00
U OF U HUNTSMAN CANCER INSTITUTE	1	5	Acute	5.00
UC DAVIS MEDICAL CENTER	1	3	Acute	3.00
UC IRVINE MEDICAL CENTER	1	13	Acute	13.00
UCLA MEDICAL CENTER	1	2	Acute	2.00
UCSF MEDICAL CENTER	2	13	Acute	6.50
UNIVERSITY MEDICAL CENTER-LV	14	54	Acute	3.86
UNIVERSITY OF WASHINGTON MED CTR	1	1	Acute	1.00

Facility	Total Admits	Total Days	Level Of Care	ALOS by Level of Care
UTAH VALLEY REGIONALMEDICAL CENTER	1	6	Acute	6.00
VA SIERRA NV HEALTH	1	3	Acute	3.00
VA SOUTHERN NEVADA	2	3	Acute	1.50
VALLEY HOSPITAL MEDICAL CENTER	7	27	Acute	3.86
VALLEY HOSPITAL MEDICAL CENTER	1	13	Rehab	13.00
VANDERBILT UNIV MEDCTR	1	2	Acute	2.00
VOGUE RECOVERY CENTER	1	1	Mental Health	1.00
WELBROOK CENTENNIALHILLS	1	10	SNF	10.00
WEST HILLS HOSPITAL-NV	1	3	Acute	3.00
WEST HILLS HOSPITAL-NV	6	35	Mental Health	5.83
WILLAMETTE VALLEY MEDICAL CENTER	1	1	Acute	1.00
WILLIAM BEE RIRIE HOSPITAL	2	3	Acute	1.50

Performance Standards & Guarantees – Self Reported

1st Quarter Plan Year 2019 07/01/2018 – 09/30/2018		
Service Performance Standard (Metric)	Guarantee Measurement	Pass/Fail
I. Quarterly and annual management reports	**100%** - Delivery of Quarterly reports within 45 days of end of reporting period as established by PEBP.	Pass
II. Notification of potential high expense cases*	**95.0%** - Designated PEBP staff will be notified within 5 business days of the UM vendors initial notification of requested service.	Pass
III. Pre-certification information shall be provided to PEBP's Fourth party administrator	**98%** - Pre-certification requests from healthcare providers shall be communicated to PEBP's First party administrator using an approved method e.g. electronically, within 5 business days of UM completing pre-certification determination.	Pass
IV. Concurrent hospital review	**98%** - Concurrent hospital reviews shall be completed and communicated using an approved method e.g. electronically within 5 business days of determination decision.	Pass

*High expense case is defined as a single-claim or treatment plan expected to exceed $1,000,000.

Hometown Health

Quarterly Update for PREMIER EPO PLAN Q3 FY 2019 (01/01/2019 - 03/31/2019)

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

Report Table of Contents

Case Management – Executive Summary

Case management (CM) is a voluntary process where the clinical professionals at the utilization management company work with patients and their family members, caregivers and other health care providers to assist with coordination of various medical treatment needs of patients. Case management services are particularly helpful when a plan participant (patient) needs complex, costly and/or high-technology services such as those related to organ and tissue transplants, certain cancer treatments, serious head injuries, hospice care or certain behavioral health issues.

Active Cases: For Q3 2019, 212 clients were identified through prior authorization and referral processes for screening by staff. Of those, 54 members met preliminary criteria for enrollment into the Case Management (CM) program and 39 accepted, representing 72.2% of eligible cases screened. Cases are identified from pre-certifications as well as potential high cost and trigger diagnosis reports.

	Screened	Eligible	Enrolled	%
Current Quarter 01/01/2019 – 3/31/2019	212	54	39	72.2%
Previous Quarter 10/01/2018 to 12/31/2018	209	55	49	89.1%
Screened Plan Year 2019 07/01/2018 to 3/31/2019	643	163	127	77.9%

For the current quarter, of the 212 clients screened:

- 157 discharged patients were managed and transitioned through case management to alternate levels of care or discharged home on an independent basis. 39 cases were actually managed in the post-discharge setting.

- 54 members met preliminary criteria for enrollment into CM. 39 members elected to participate in the CM program. 15 members were not enrolled due to various factors related to lack of MD referrals, end of life issues, declined consents, and other social behavior influences.

- In addition to 39 new cases, 42 extended cases were carried over from previous monitoring periods, bringing total enrollment for the quarter to 81 with typical case duration of 9 months to 2 years as members regain function and stabilize or their condition deteriorates.

Case Management – Executive Summary (continued)

The majority of clients referred to CM continues to be from the Utilization Review nurses at time of referral, time of hospital admission, or time of transition to an alternate level of care. These referrals make up 75% of the referrals to Case Management. 25% of the cases screened came from physicians, plan referrals, specialty clinics and other health care facilities.

Case management estimated cost savings is $173,460 for the third quarter of Plan Year 2019. Additional savings will be realized under Healthscope for the early intervention and referrals/resources channeled to in-network provider services.

Conclusion

During the third quarter of Plan Year 2019, 212 unique members were screened for possible case management intervention. Of the 212, 54 members met preliminary criteria for enrollment into CM and 39 members (72.2%) elected to enroll in the program.

Case Management – Referral Reason Report

	Quarterly 1/1/2019 to 3/31/2019	Year to Date 7/1/2018 to 3/31/2019
CM Trigger List	212	643
High Dollar	Included in Trigger List	Included in Trigger List
High Risk	Included in Trigger List	Included in Trigger List
Other		
Totals	**212**	**643**

Case Type – Summary Report

	Quarterly 1/1/2019 to 3/31/2019					Year to Date 07/01/2018 to 3/31/2019				
	New Cases Opened	Full Cases Opened	Benefit Mgmt	LOAs	Totals	New Cases Opened	Full Cases Opened	Benefit Mgmt	LOAs	Totals
Bariatric	11	21	8		**40**	23	37	12		**72**
LCM	21	40	23		**84**	82	112	42		**236**
BH/CHEM	6	15	9		**30**	17	23	12		**52**
Transplant	1	5	2		**8**	5	9	11		**25**
Other										
Totals	**39**	**81**	**42**	**0**	**162**	**127**	**181**	**77**	**17**	**385**
Total Open Cases	**183**									

Case Management – Summary Report

Report Glossary:

New Cases Opened:
Number of cases opened to full (traditional) case management within the period.

Full Cases Opened
Number of existing cases carried over from previous reporting periods remaining active during current reporting period. (Excludes new cases opened within period).

Benefit Management Cases:
Referrals for simple discharge planning, resources, brief education, CM consults, etc. within the period.

LOAs
Extra-contractual agreements executed within the period.

Case Management – Saving Detail for Open & Closed Cases

1/1/2019 to 3/31/2019						
Case Type	**Care Level Status**	**Vendor Negotiations**	**Averted Adm Savings**	**Change in Level of Care**	**Proposed Alternative Plan**	**Total Savings**
LCM	Active		$ 49,950			$ 49,950
LCM	Active		$ 48,100			$ 48,100
BH/CHEM	Active			$ 29,700		$ 29,700
BH/CHEM	Active			$ 8,580		$ 8,580
BH/CHEM	Active			$ 3,300		$ 3,300
BH/CHEM	Active			$ 4,950		$ 4,950
BH/CHEM	Active			$ 17,490		$ 17,490
BH/CHEM	Active			$ 3,250		$ 3,250
BH/CHEM	Active			$ 3,300		$ 3,300
				$ 4,840		$ 4,840
Quarterly Savings by Type			$98,050	$75,410		
Total Quarterly Savings Q3 2019						$173,460
Q1 + Q2 + Q3 2019 Savings						$496,010
Year To Date ROI						$496,010

Utilization Management – Executive Summary

The PEBP Consumer Driven Health Plan (CDHP) requires participants to obtain a pre-certification for certain medical services such as inpatient hospital admissions, skilled nursing facility admissions and bariatric weight loss surgeries. This requirement is also referred to as utilization management, utilization review, concurrent and retrospective review. The purpose of utilization management is to evaluate the appropriateness, the medical need and efficiency of certain healthcare services and procedures.

Inpatient Utilization Overview:

Based on the third quarter, the PEBP population was 42,321 (average monthly lives for the quarter). Third quarter data shows 583 member admissions and 556 member discharges. Discharges for the third quarter were 13.38 members per thousand lives managed. Discharges annualized were 53.50 members per thousand lives managed. Bed days for the third quarter were 71.99 members per thousand lives managed. Bed days annualized were 287.77 members per thousand lives managed. The average length of stay was 5.38 days.

Inpatient Authorization and Denials:

The data show 556 authorized admissions were discharged in the quarter. General Med/Surg discharges composed the majority of all discharges with 107 (68.15%), Mental Health 23 (14.65%), Mother and Newborn 22 (14.01%), Rehab 2 (1.27%), NICU with 2 (1.27%), and Skilled Nursing with 1 (0.64%) total discharges.

Quarter/Year	General Med/Surg	Mental Health	Mother & Newborn	Rehab	NICU	Skilled Nursing
3Q 2018	107 (68.15%)	23 (14.65%)	22 (14.01%)	2 (1.27%)	2 (1.27%)	1 (0.64%)

Third quarter data shows 1 admission denials for a total of 0 denial days. The 1 admit with 0 day(s) was "*DENIED NOT COVERED BY PLAN* " by the plan.

Utilization Management – Executive Summary (Continued)

Reviewing Discharges by Specialty for the this Quarter:

- **General Med/Surg** discharges were 107, with a total of 370 authorized days and an average LOS of 3.46 days. Bed days of 43.70 per thousand lives managed for the quarter *(annualized 174.70 per thousand)*, and 12.63 members discharged per thousand of lives managed for the quarter *(annualized 50.50 per thousand).*

- **Mental Health** discharges were 23, with a total of 161 authorized days and an average LOS of 7.00 days. Bed days of 19.21 per thousand lives managed for the quarter *(annualized 76.78 per thousand)* and 2.75 members were discharged per thousand lives managed for the quarter *(annualized 11.00 per thousand).*

- **Mother & Newborn** discharges were 22, with a total of 78 authorized days and an average LOS of 3.55 days. Bed days of 9.17 per thousand lives managed for the quarter *(annualized 36.67 per thousand)* and 2.57 members were discharged per thousand lives managed for the quarter *(annualized 10.26 per thousand).*

- **Rehab** discharges were 2, with a total of 38 authorized days and an average LOS of 19.00 days. Bed days of 14.36 per thousand lives managed for the quarter *(annualized 57.41 per thousand)* and 0.76 members were discharged per thousand lives managed for the quarter *(annualized 3.02 per thousand).*

- **NICU** discharges were 2, with a total of 56 authorized days and an average LOS of 28.00 days. Bed days of 19.23 per thousand lives managed for the quarter *(annualized 76.87 per thousand)* and 0.69 members were discharged per thousand lives managed for the quarter *(annualized 2.75 per thousand).*

- **Skilled Nursing** discharges were 1, with a total of 19 authorized days and an average LOS of 19.00 days. Bed days of 6.47 per thousand lives managed for the quarter *(annualized 25.87 per thousand)* and 0.34 members were discharged per thousand lives managed for the quarter *(annualized 1.36 per thousand).*

Utilization Management – Executive Summary (Continued)

Age and Gender Distribution:
Third quarter discharges show 36.9 % of the members discharged fall in the age bracket of 50-64. Overall women make-up 63.69 % of all discharges in this quarter.

Out-Patient Utilization and Denials *(Services Include: Ambulatory Services, Diagnostic, Dialysis, Durable Medical Equipment, Home Health, Hospice, Infusion, Medical Office Visits, Pharmaceutical services, Medical Transportation, Mental Health Outpatient, Rehabilitation, Outpatient Surgery, Infusion, Transplant, Prenatal Care)***:**

Third quarter outpatient utilization consisted of 971 requests for services authorized. Authorizations for services are as follows: Medical Office Services requests composed 35.53% of total requests. Outpatient Surgical Services composed 33.37% of total requests. Durable Medical Equipment composed 17.51% of total requests. Home Health Services composed 3.09%. Ambulatory Services composed 2.47%. Infusion Services composed 1.96 % and Mental Health and Substance Abuse composed 1.03% of total request. The remaining requests composed 0.81% of total requests and include: Medical Transportation, Outpatient Mental Health, Outpatient Transplant Services, Dialysis Services, Cardiac Rehabilitation Services, and Hospice Services (0.31%, 0.10%, 0.10%, 0.10%, 0.10%, and 0.10% respectively).

There were 18 outpatient requests for services denied during this quarter of FY 2018. The requests included 5 for ***Durable Medical Equipment,*** 4 for ***Medical Office Services,*** and 2 for ***Outpatient Surgical Services*** were denied as not covered by plan. Other request included 2 for ***Durable Medical Equipment (DME)*** were denied not medically necessary. Lastly, 2 for ***Medical Office Services,*** 2 for ***Outpatient Surgical Services***, and for 1 ***Durable Medical Equipment (DME)*** were service out of plan.

Estimated savings provided do not include denials of coverage for services designated as non covered in the PEBP Master Plan document or potential savings from Letters of Agreement negotiated by Hometown health, but administered by PEBP and Healthscope.

Inpatient Utilization

3rd Quarter Plan Year 2019 01/01/2019 - 03/31/2019			
Average Population	**8,618**	Quarterly Discharges Per Thousand	**19.74**
Total Discharges	**157**	Quarterly Bed Days Per Thousand	**112.15**
Days Approved	**722**		
Total Reviews Performed			
Admissions	**162**		
Concurrent	**110**		
Retrospective	**52**		

*The above table provides an overview of inpatient pre-certification/authorizations.

Inpatient Authorizations & Denials

3rd Quarter Plan Year 2019
01/01/2019 - 03/31/2019

Admissions	Total	General Med/Surg	Mental Health	Mother & Newborn	Rehab	NICU	Skilled Nursing	
# of Discharges	157	107	23	22	2	2	1	
Quarterly Discharges per 1000	19.74	12.63	2.75	2.57	0.76	0.69	.34	

Total Denied

Denials	Surgical	Medical	Detox	Obstetrical	Rehab	Mental Health	Observation	Total
Total Number of Denied Requests	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Denied, Not Medically Necessary	0	0	0	0	0	0	0	**0**
Denied, Not Covered by Plan	1	0	0	0	0	0	0	**1**
Denied, Insufficient Medical Information	0	0	0	0	0	0	0	**0**

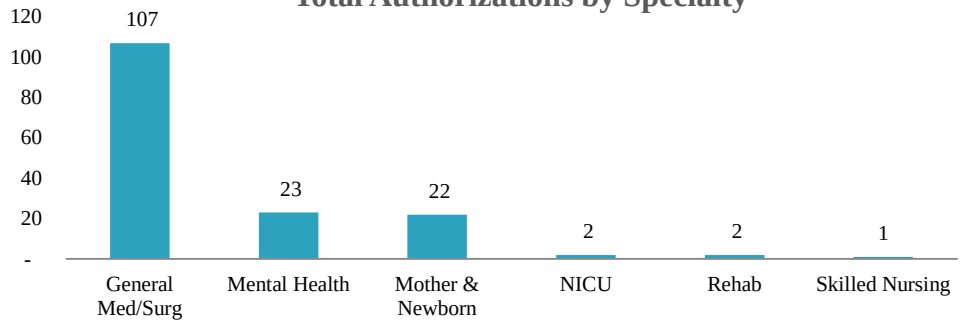
*The above tables provide an overview of inpatient authorization by utilization data. Total denied days are derived from prospective and concurrent reviews.

Inpatient Discharge Information

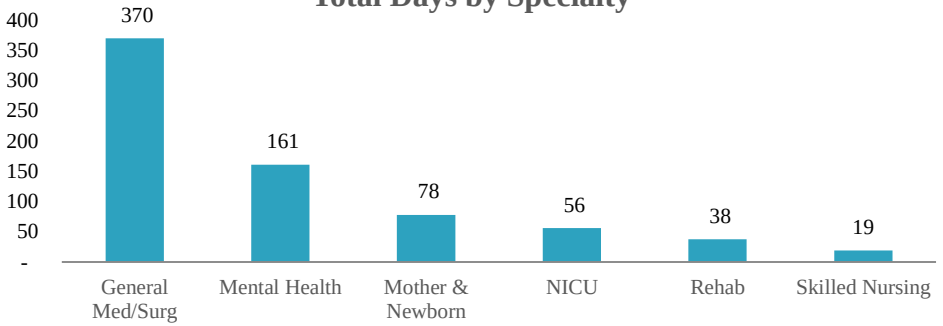
3rd Quarter Plan Year 2018 01/01/2018 - 03/31/2018					
Discharges by Specialty	Total Auths	Total Days	Average LOS	Quarterly Beddays/1,000	Quarterly Discharges/1,000
General Med/Surg	107	370	3.46	43.70	12.63
Mental Health	23	161	7.00	19.21	2.75
Mother & Newborn	22	78	3.55	9.17	2.57
NICU	2	56	28.00	19.23	0.69
Rehab	2	38	19.00	14.36	0.76
Skilled Nursing	1	19	19.00	6.47	0.34

*The above tables provide an overview of discharges by category and as a whole, in addition the table provides a further breakout of the medical category. Graphic representation of Discharges by specialty is located on pages 16 through 18 of this report.

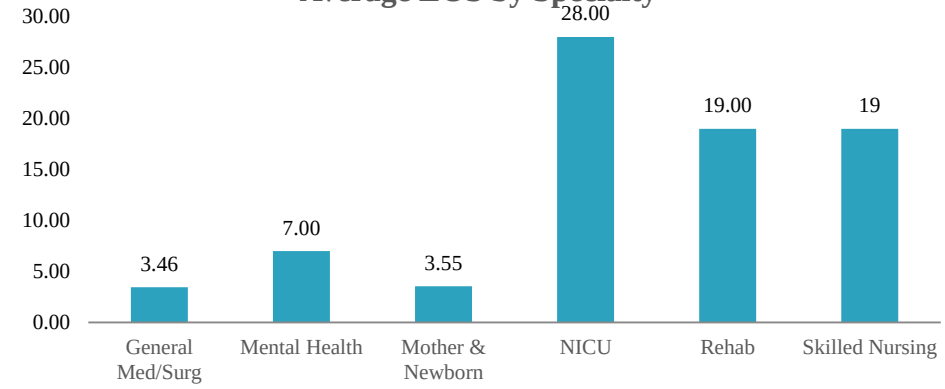
Total Authorizations by Specialty



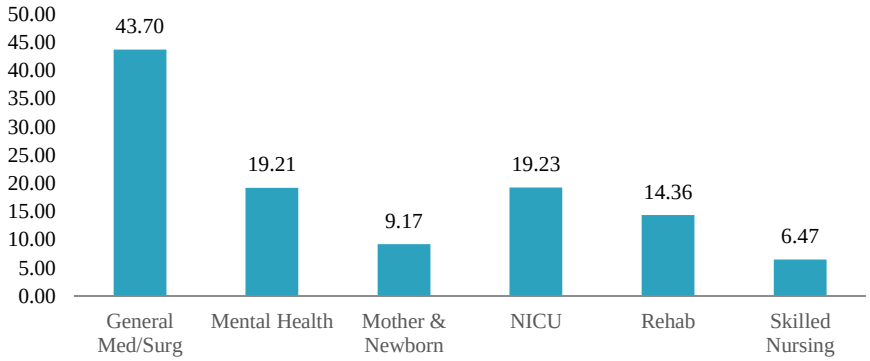
Total Days by Specialty



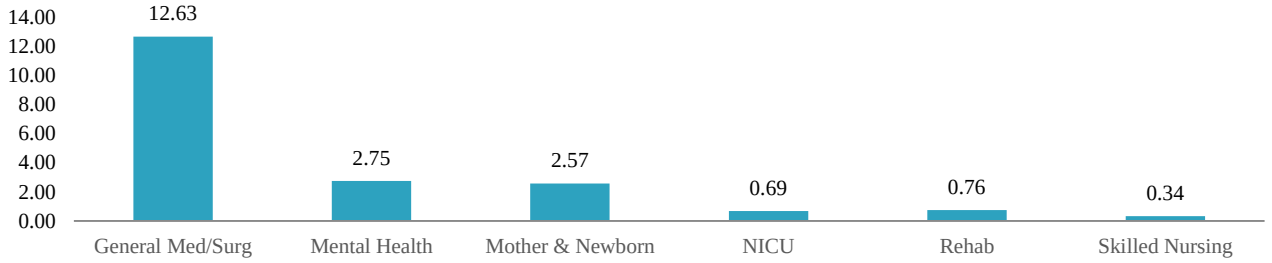
Average LOS by Specialty



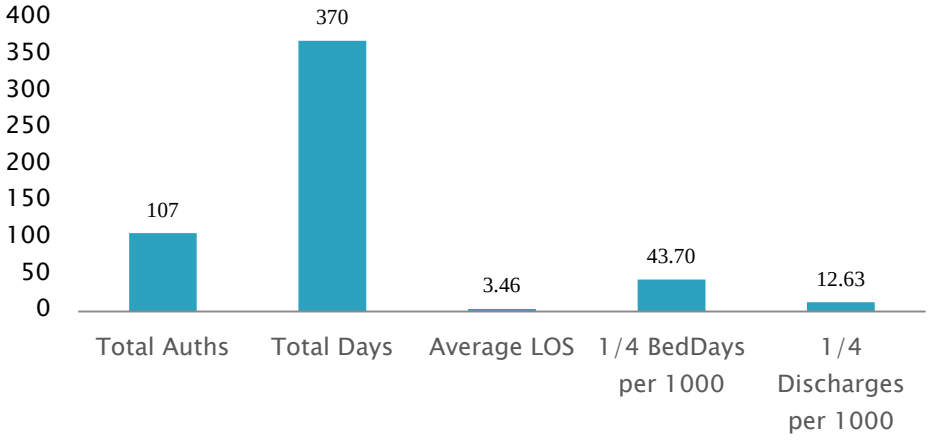
Average Bed Days per Thousand



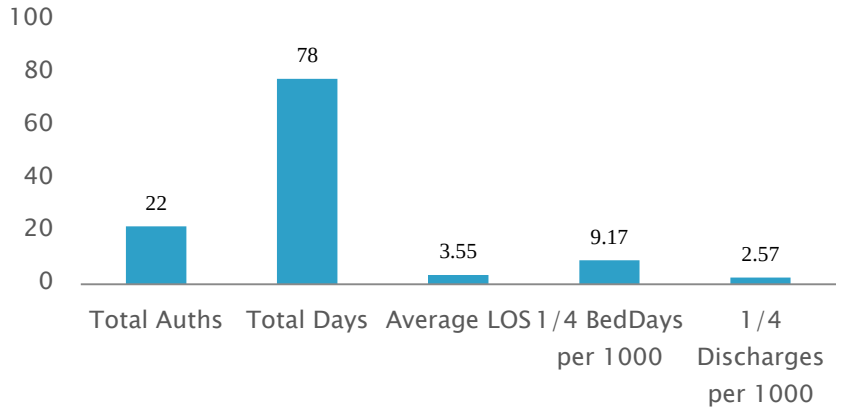
Discharges per Thousand



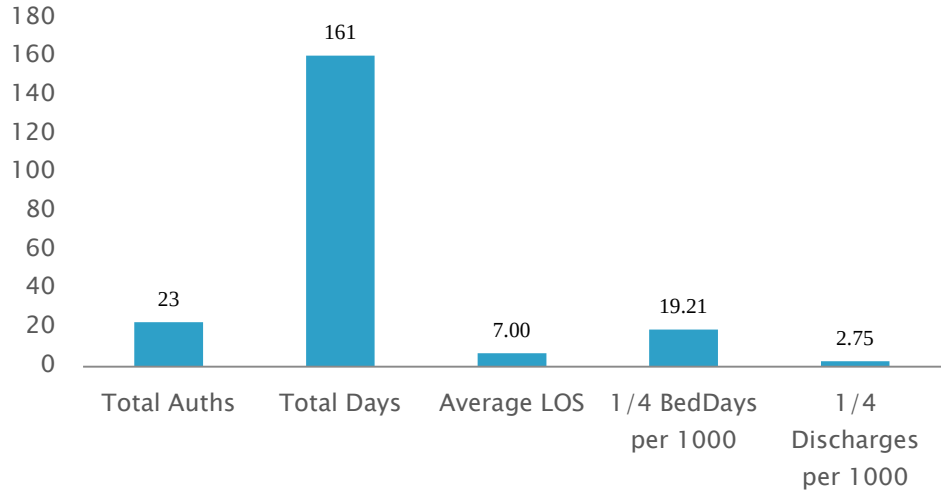
General Med/Surg



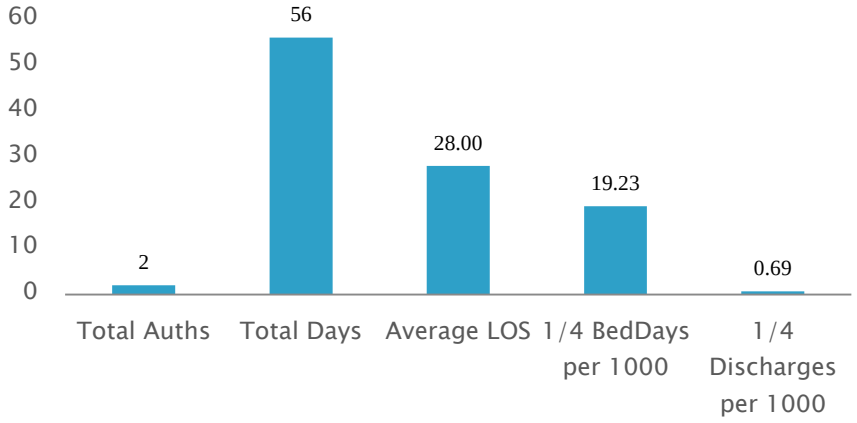
Mental Health

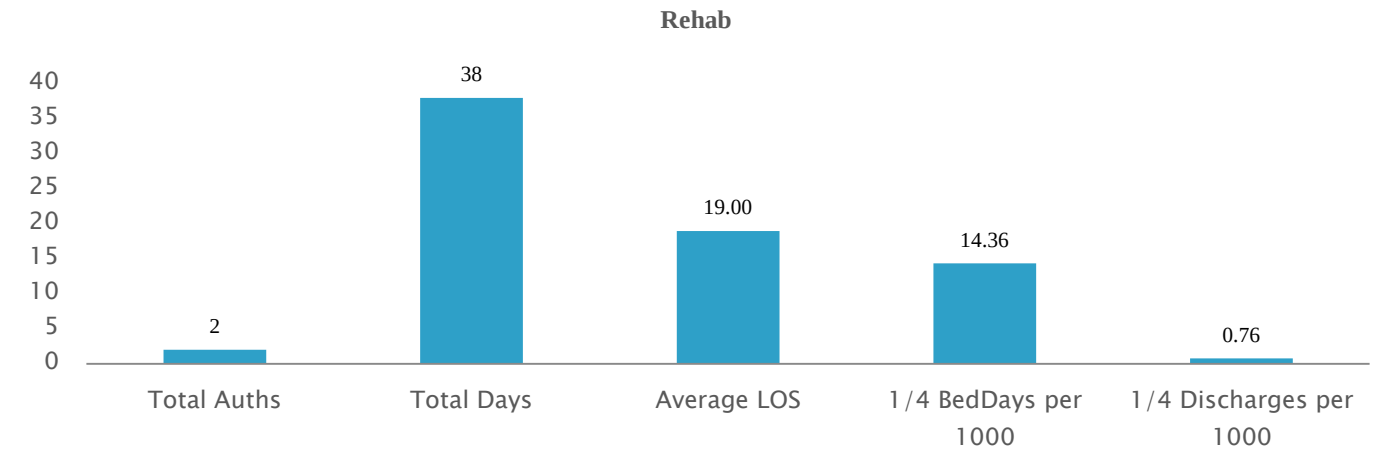


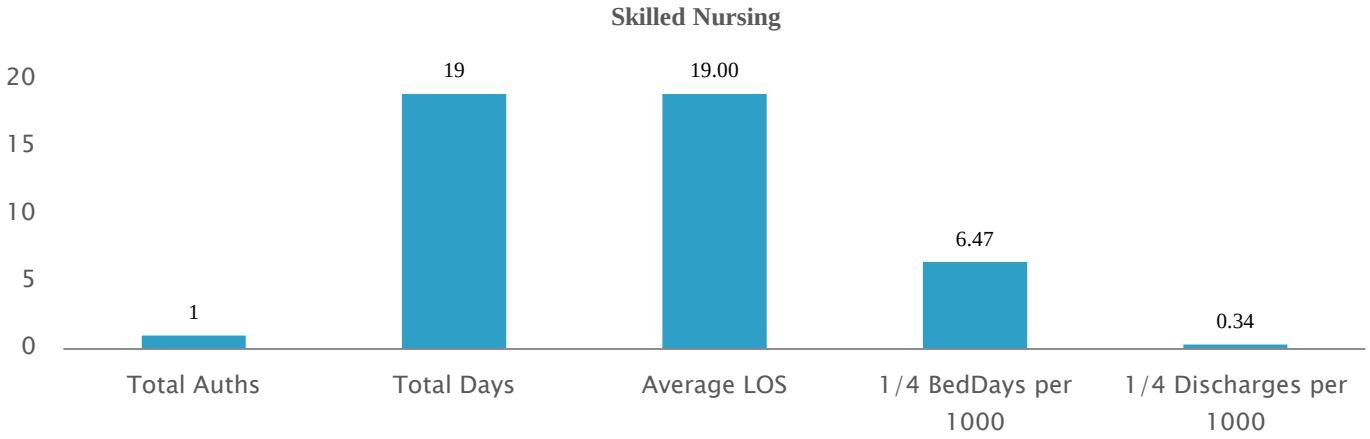
Mother & Newborn



NICU

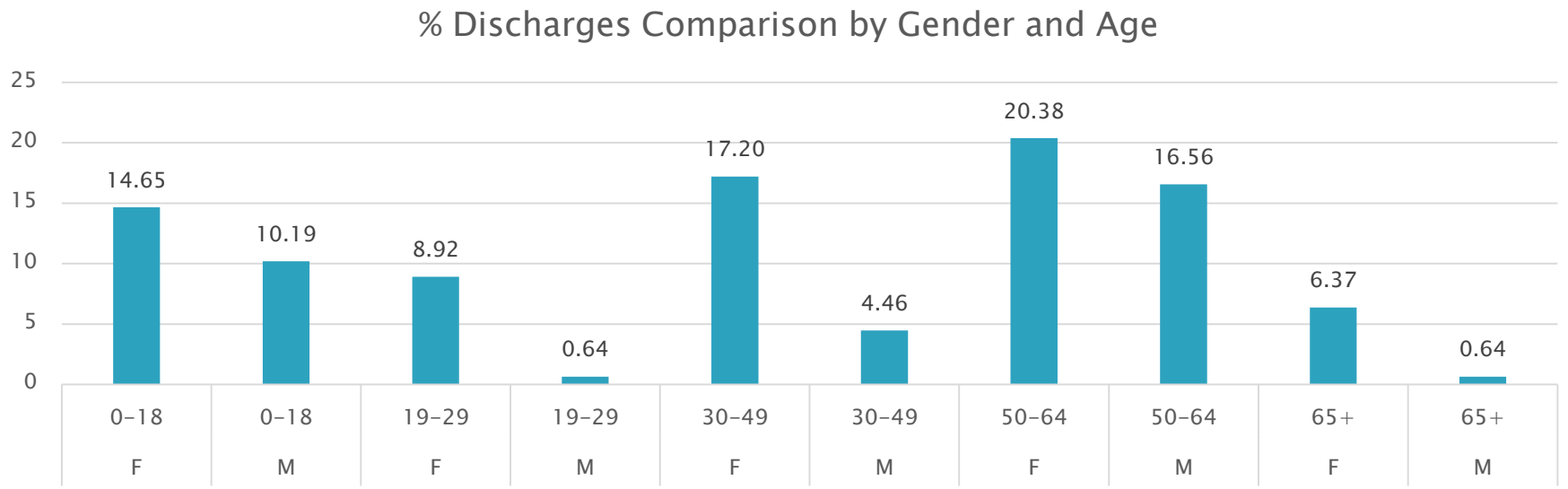



Rehab
40
35
30
25
20
15
10
5
0
38
19.00
14.36
2
0.76
Total Auths
Total Days
Average LOS
1/4 BedDays per 1000
1/4 Discharges per 1000


Skilled Nursing
20
15
10
5
0
19
19.00
6.47
1
0.34
Total Auths
Total Days
Average LOS
1/4 BedDays per 1000
1/4 Discharges per 1000

Age & Gender Distribution

01/01/2019 - 03/31/2019 Age Categories	0 - 18	19 - 29	30 - 49	50 - 64	65+	Total
Female (#)	23	14	27	32	10	**106**
Male (#)	16	1	7	26	1	**51**
Total (#)	**39**	**15**	**34**	**58**	**11**	**157**



*The above table provides a breakout of discharged members by age categories, the above graph provides a comparison of male to female discharges in the same age categories.

Outpatient Authorizations & Denials

Authorizations	
MEDICAL OFFICE SERVICES	345
OUTPATIENT SURGICAL SERVICES	324
DURABLE MEDICAL EQUIPMENT	170
OUTPATIENT REHABILITATIVE THERAPY SERVICE	41
HOME HEALTH SERVICES	30
AMBULATORY SERVICES	24
INFUSION SERVICES, EQUIPMENT AND SUPPLIES	19
MENTAL HEALTH & SUBSTANCE ABUSE PARTIAL	10
MEDICAL TRANSPORTATION SERVICES	3
OUTPATIENT MENTAL HEALTH SERVICES	1
CARDIAC REHABILITATION SERVICES	1
DIALYSIS SERVICES	1
HOSPICE SERVICES	1
OUTPATIENT TRANSPLANT SERVICES	1
Totals	**971**

Denials	Ambulatory Services	Outpatient	Medical Office Services	DME	Total
Denied, Not Covered by Plan	0	2	4	5	11
Denied, Not Medically Necessary	0	0	0	2	2
Denied Service Out of Plan	0	2	2	1	5
Total Number of Denied Requests	**0**	**4**	**6**	**8**	**18**

Appendix A

Medical Discharges by Facility and Level of Care

Facility	Total Admits	Total Days	Level Of Care	ALOS by Level of Care
CARSON TAHOE BEHAVIORAL HLTH SVCS	5	21	Mental Health	4.2
CARSON TAHOE REGIONAL MEDICAL CTR	34	93	Acute	2.7
CARSON TAHOE REGIONAL MEDICAL CTR	1	2	Mental Health	2.0
CARSON VALLEY MEDICAL CENTER	1	2	Acute	2.0
HUMBOLDT GENERAL HOSPITAL	1	1	Acute	1.0
NORTHEASTERN NEV R/H	3	6	Acute	2.0
ORMSBY POST ACUTE REHAB	1	19	SNF	19.0
RENO BEHAVIORAL HEALTHCARE HOSP	11	102	Mental Health	9.3
RENOWN REGIONAL MEDICAL CENTER	79	327	Acute	4.1
RENOWN REHAB HOSPITAL	2	38	Rehab	19.0
RENOWN SOUTH MEADOWS	8	10	Acute	1.3
STANFORD MEDICAL CENTER	1	37	Acute	37.0
SUTTER WEST BAY HOSPCPMC DAVIES	1	4	Acute	4.0
TAHOE FOREST HOSPITAL	1	2	Acute	2.0
U OF U NEUROPSYCHIATRIC INSTITUTE	1	9	Mental Health	9.0
VICTORIA MEDICAL CANCUS SA DE CV	1	1	Acute	1.0
WEST HILLS HOSPITAL-NV	5	27	Mental Health	5.4

Facility	Total Admits	Total Days	Level Of Care	ALOS by Level of Care

Facility	Total Admits	Total Days	Level Of Care	ALOS by Level of Care

Performance Standards & Guarantees – Self Reported

3rd Quarter Plan Year 2018 01/01/2018 – 03/31/2018		
Service Performance Standard (Metric)	Guarantee Measurement	Pass/Fail
I. Quarterly and annual management reports	**100%** - Delivery of Quarterly reports within 45 days of end of reporting period as established by PEBP.	Pass
II. Notification of potential high expense cases*	**95.0%** - Designated PEBP staff will be notified within 5 business days of the UM vendors initial notification of requested service.	Pass
III. Pre-certification information shall be provided to PEBP's third party administrator	**98%** - Pre-certification requests from healthcare providers shall be communicated to PEBP's third party administrator using an approved method e.g. electronically, within 5 business days of UM completing pre-certification determination.	Pass
IV. Concurrent hospital review	**98%** - Concurrent hospital reviews shall be completed and communicated using an approved method e.g. electronically within 5 business days of determination decision.	Pass

*High expense case is defined as a single-claim or treatment plan expected to exceed $1,000,000.

4.4.3.

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

   Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

   4.4. Receipt of quarterly vendor reports for the period ending March 31, 2019:

      4.4.3. The Standard Insurance – Basic Life and Long-Term Disability Insurance

The Standard

Quarterly Report: Basic Life Insurance and Long Term Disability:
Quarter Ending
March 31, 2019

Report Table of Contents

Basic Life Insurance & Long Term Disability Executive Summary

Most Recent Five Plan Years: July 01, 2014 to March 31, 2019

This is the third quarter report for the 2018-19 plan year, providing information for the period beginning July 1, 2014 and ending March 31, 2019.

Basic Life

On a plan year over year basis, basic life claim incidence is relatively flat compared to the 2017-18 plan year, slightly down for employees and up for retirees (page 4). From a loss ratio standpoint, the overall loss ratio (page 5) is up noticeably, 89% for this plan year compared to 77% in 2017-18. The increase is primarily driven by two things, a large year over year increase in reserves for waiver of premium claims for employees and the negotiated 5% rate decrease implemented for basic life at the start of the plan year.

Claim incidence and liability (page 4) is up year over year for heart/circulatory claims and down for cancer claims. That's interesting given PEBP's history of higher incidence and liability for heart/circulatory claims and lower incidence and liability for cancer claims than The Standard's overall block of public sector business. The anomaly is growing.

Long Term Disability

LTD claim incidence (page 7) is reported on an incurred basis, claims are charged to the plan year in which disability started. Given the 180 day Benefit Waiting Period, there is a lag for new claim activity in the reports. Last year at this time we had 7 claims incurred in the 2017-18 plan year. That number has increased to 28 as of the end of the current quarter. This year through the 3rd quarter we've only received 4 new claims for the plan year. That bodes well for overall plan year results.

LTD loss ratios (page 8) are reported on a cash basis, without regard to incurred date. Year to date results look very good with a loss ratio of 18%, compared to 24% for the 2017-18 plan year.

Like basic life, LTD claim incidence and liability (page 7) is up noticeably for heart and circulatory conditions and your results are much worse than the rest of our public sector block. On a positive note, PEBP's LTD incidence and liability for back and musculoskeletal conditions is better than the rest of our block.

Basic Life Insurance Claims by Plan Year and Participant Type

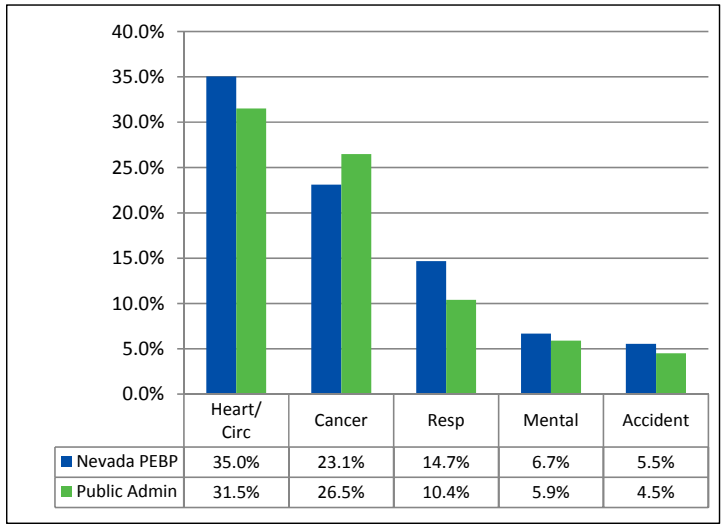
Most Recent Five Plan Years: July 01, 2014 to March 31, 2019

	From Jul-14 Through Jun-15		From Jul-15 Through Jun-16		From Jul-16 Through Jun-17		From Jul-17 Through Jun-18		From Jul-18 Through Jun-19	
Participant Type	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**
Actives	39	1.7	41	1.7	51	2.0	41	1.6	22	0.8
Retirees	268	19.2	270	18.3	319	21.4	288	19.0	155	9.9
Totals	**307**	**8.3**	**311**	**7.9**	**370**	**9.2**	**329**	**8.0**	**177**	**4.2**

Basic Life Insurance Claims by Diagnostic Category

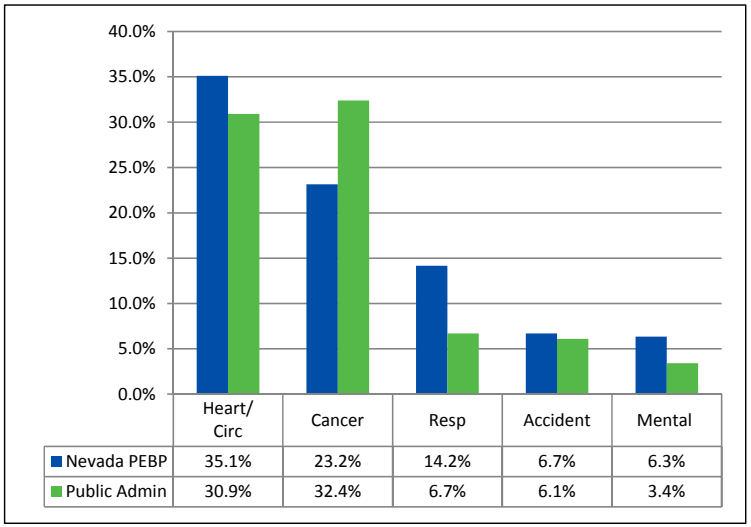
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Heart/ Circ	Cancer	Resp	Mental	Accident
Nevada PEBP	35.0%	23.1%	14.7%	6.7%	5.5%
Public Admin	31.5%	26.5%	10.4%	5.9%	4.5%

Top Five Diagnostic Categories by Liability

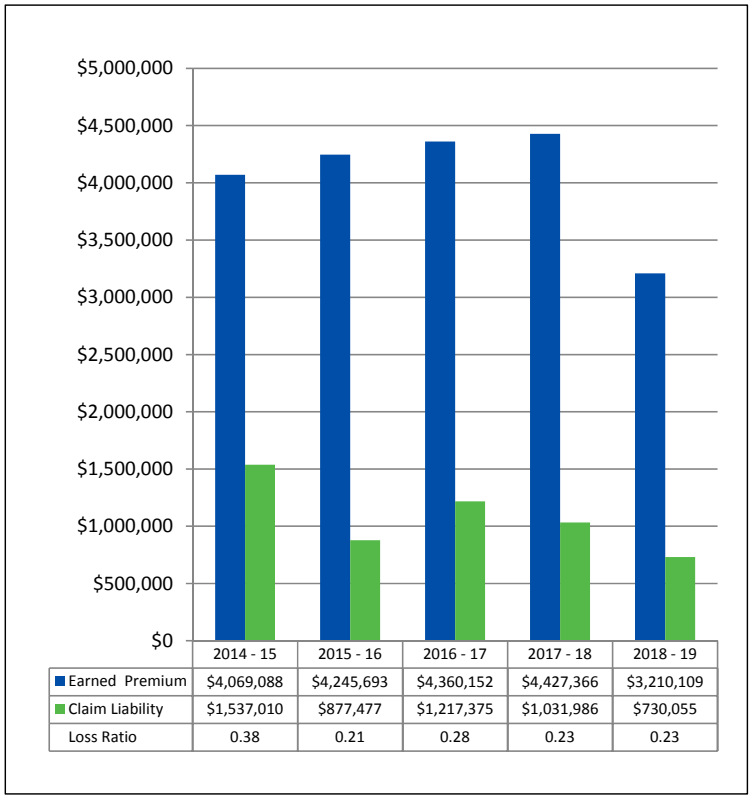


	Heart/ Circ	Cancer	Resp	Accident	Mental
Nevada PEBP	35.1%	23.2%	14.2%	6.7%	6.3%
Public Admin	30.9%	32.4%	6.7%	6.1%	3.4%

Basic Life Insurance Earned Premiums & Liability by Participant Type

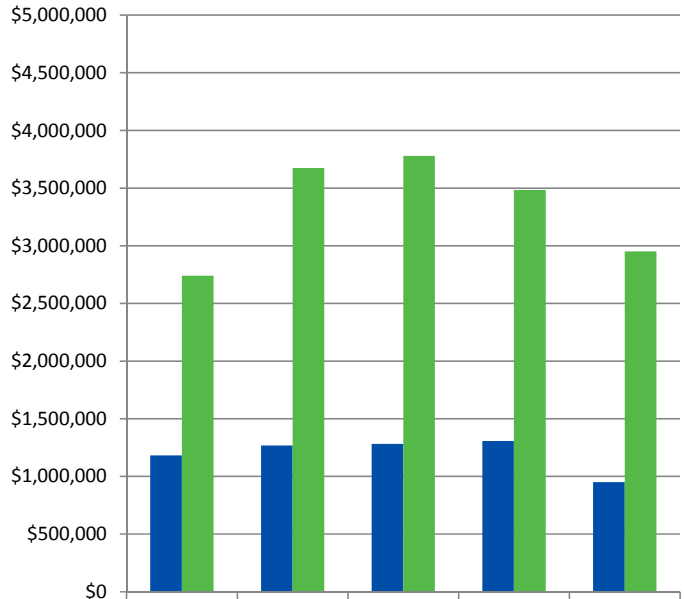
Most Recent Five Plan Years: July 01, 2014 to March 31, 2019

Active Participants



	2014 - 15	2015 - 16	2016 - 17	2017 - 18	2018 - 19
Earned Premium	$4,069,088	$4,245,693	$4,360,152	$4,427,366	$3,210,109
Claim Liability	$1,537,010	$877,477	$1,217,375	$1,031,986	$730,055
Loss Ratio	0.38	0.21	0.28	0.23	0.23

Retired Participants

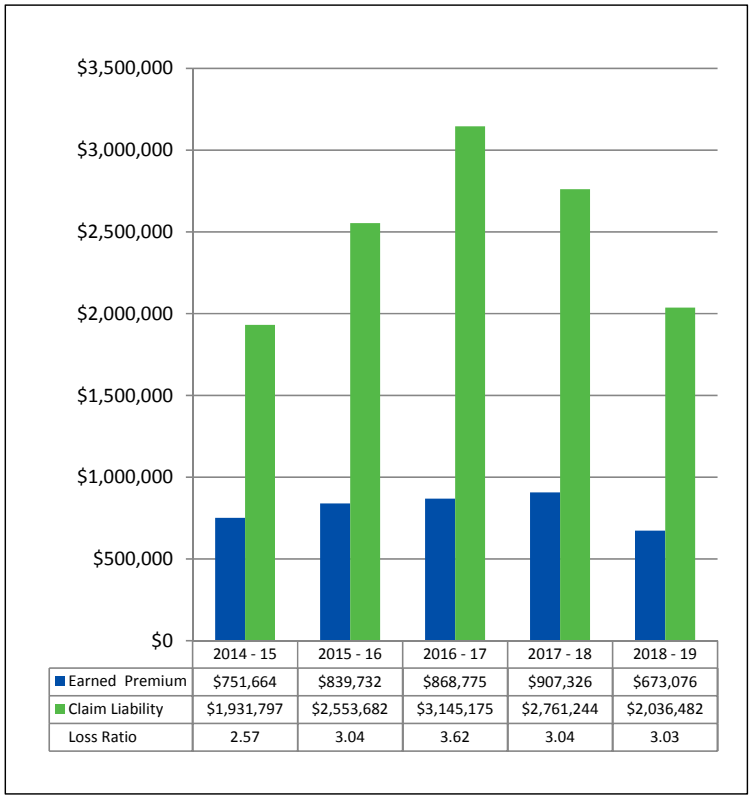


	2014 - 15	2015 - 16	2016 - 17	2017 - 18	2018 - 19
Earned Premium	$1,182,171	$1,268,470	$1,282,457	$1,306,604	$949,974
Claim Liability	$2,740,269	$3,674,745	$3,779,175	$3,485,155	$2,952,087
Loss Ratio	2.32	2.90	2.95	2.67	3.11

Basic Life Retiree Insurance Earned Premiums & Liability by Participant Type

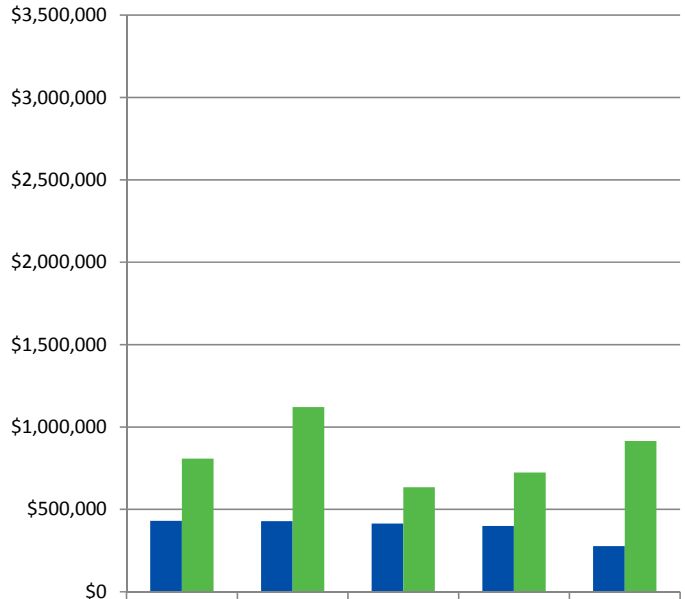
Most Recent Five Plan Years: July 01, 2014 to March 31, 2019

State Retired Participants



	2014 - 15	2015 - 16	2016 - 17	2017 - 18	2018 - 19
Earned Premium	$751,664	$839,732	$868,775	$907,326	$673,076
Claim Liability	$1,931,797	$2,553,682	$3,145,175	$2,761,244	$2,036,482
Loss Ratio	2.57	3.04	3.62	3.04	3.03

Non-State Retired Participants



	2014 - 15	2015 - 16	2016 - 17	2017 - 18	2018 - 19
Earned Premium	$430,507	$428,738	$413,682	$399,278	$276,898
Claim Liability	$808,472	$1,121,063	$634,000	$723,911	$915,605
Loss Ratio	1.88	2.61	1.53	1.81	3.31

Long Term Disability Claims by Plan Year

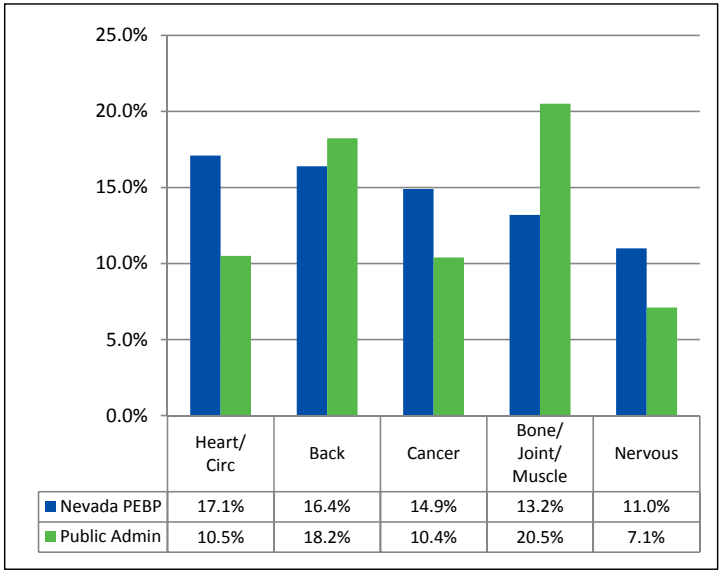
Most Recent Five Plan Years: July 01, 2014 to March 31, 2019

	From Jul-14 Through Jun-15		From Jul-15 Through Jun-16		From Jul-16 Through Jun-17		From Jul-17 Through Jun-18		From Jul-18 Through Jun-19	
	Count	Inc./ 1000	Count	Inc./ 1000	Count	Inc./ 1000	Count	Inc./ 1000	Count	Inc./ 1000
LTD Claims	47	2.0	28	1.1	37	1.5	28	1.1	4	0.2

Long Term Disability Claims by Diagnostic Category

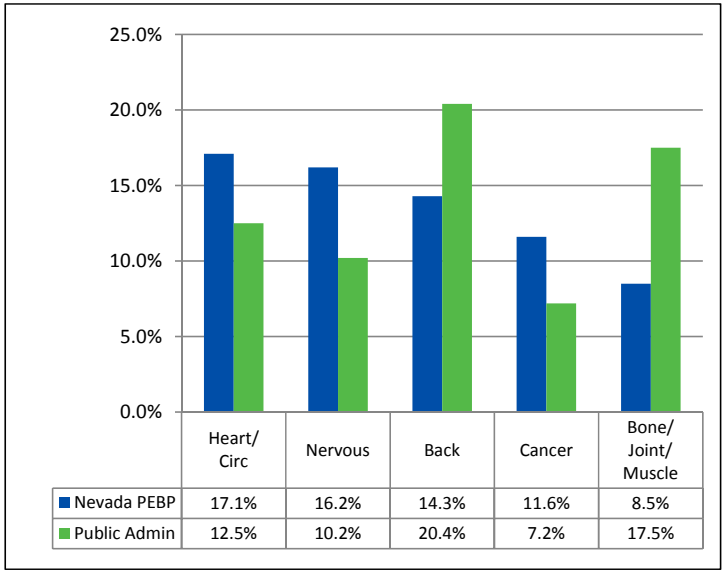
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Heart/ Circ	Back	Cancer	Bone/ Joint/ Muscle	Nervous
Nevada PEBP	17.1%	16.4%	14.9%	13.2%	11.0%
Public Admin	10.5%	18.2%	10.4%	20.5%	7.1%

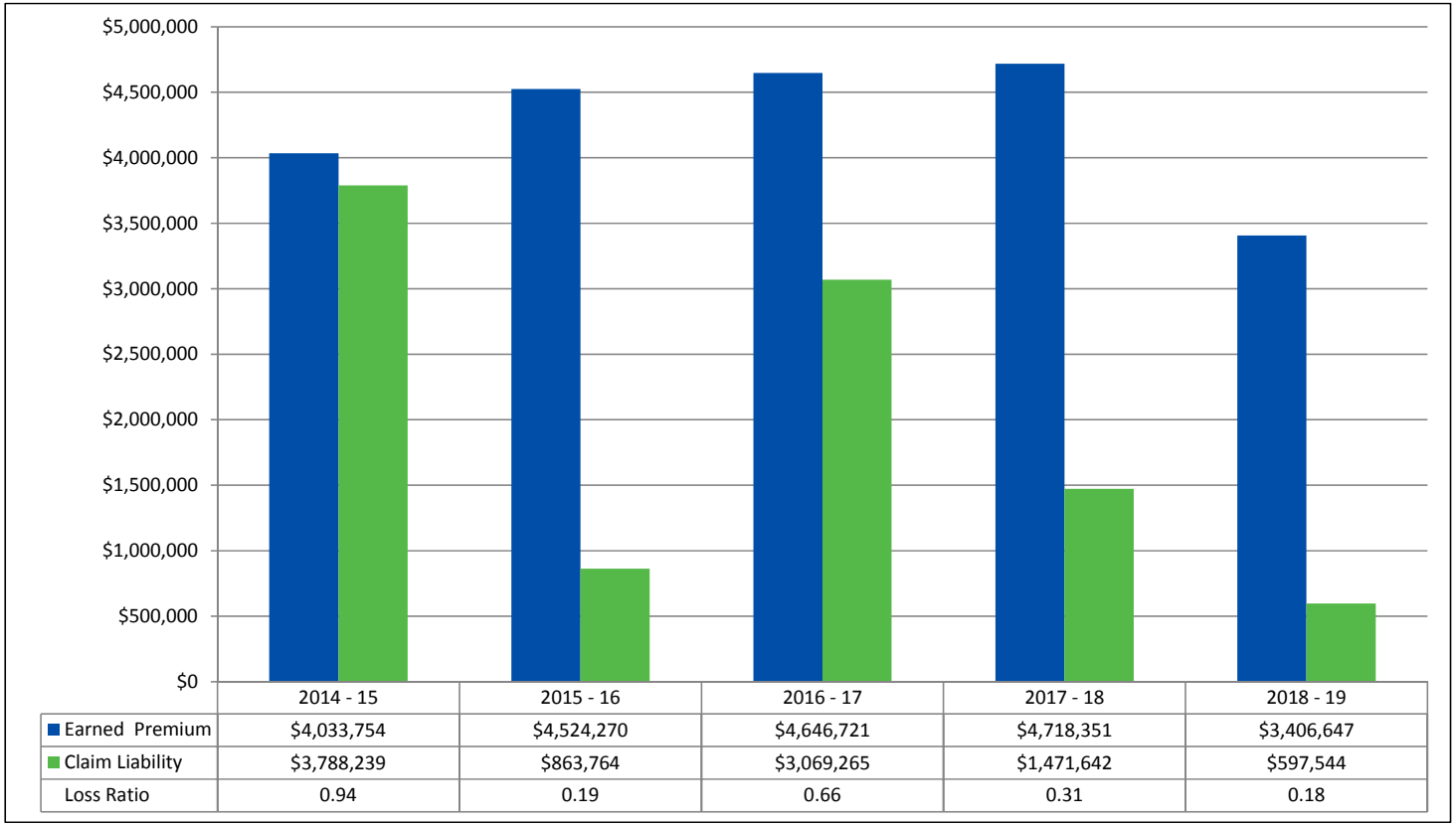
Top Five Diagnostic Categories by Liability



	Heart/ Circ	Nervous	Back	Cancer	Bone/ Joint/ Muscle
Nevada PEBP	17.1%	16.2%	14.3%	11.6%	8.5%
Public Admin	12.5%	10.2%	20.4%	7.2%	17.5%

Long Term Disability Earned Premiums & Liability

Most Recent Five Plan Years: July 01, 2014 to March 31, 2019



	2014 - 15	2015 - 16	2016 - 17	2017 - 18	2018 - 19
Earned Premium	$4,033,754	$4,524,270	$4,646,721	$4,718,351	$3,406,647
Claim Liability	$3,788,239	$863,764	$3,069,265	$1,471,642	$597,544
Loss Ratio	0.94	0.19	0.66	0.31	0.18

Claim Appeals

Quarterly Update for Plan Year to Date July 01, 2018 to March 31, 2019

	In Process	Decision Upheld	Decision Overturned	Total
Claim Appeals				
Life Insurance Claims	1	1	0	2
Long-Term Disability Claims	0	1	1	2
Short-Term Disability Claims	0	0	0	0
Total Appeals	**1**	**2**	**1**	**4**

4.4.4.

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

   Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

   4.4. Receipt of quarterly vendor reports for the period ending March 31, 2019:

      4.4.4. Towers Watson's One Exchange – Medicare Exchange

Nevada Public Employees Benefit Program

Quarterly Update – 3rd Quarter Plan Year 2019

Willis Towers Watson's Individual Marketplace

July 8, 2019

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd Quarter Plan Year 2019

Executive Summary

Plan Enrollment:

- At the end of Q3 2019, PEBP's total enrollment into Medicare policies through Willis Towers Watson's Individual Marketplace decreased to 12,713. Since inception, 100 carriers have been selected by PEBP's retirees with current enrollment in 1,204 different plans.
- Medicare Supplement (MS) plan selection remained consistent at 80% of the total population with the majority of participants selecting AARP and Anthem BCBS of Nevada as their insurer; each carrier holds plans for 6,373 and 2,036 enrollees respectively. The average monthly premium cost for MS plans remained consistent at $147.
- The percentage of Medicare Advantage (MA or MAPD) plans selected remaining consistent at 20%. Top MA carriers include Hometown Health Plan with 1,321 individual plan selection and Humana with 375 individual plan selections. The average monthly premium cost to PEBP participants is $28.

Customer Satisfaction:

- Q3 2019, PEBP participant satisfaction with Enrollment Calls increased slightly with an average satisfaction score result of 4.8 out of 5.0 based on 58 surveys returned.
- The customer satisfaction score results for Service Calls decreased slightly for Q3 when compared to the prior quarter. For Q2 2019, the average satisfaction score results were 4.7 out of 5.0. For Q3 2019, the score was 4.8 with 419 survey responses.
- The combined average satisfaction score for Enrollment Calls and Service Calls was 4.4 out of 5.0 for Q3 2019.
- For Funding Calls, PEBP customer satisfaction was 4.3 out of 5.0. This was an increase when compared to Q2 2019. There were 104 survey responses in Q2 compared to 146 survey responses for Q3.

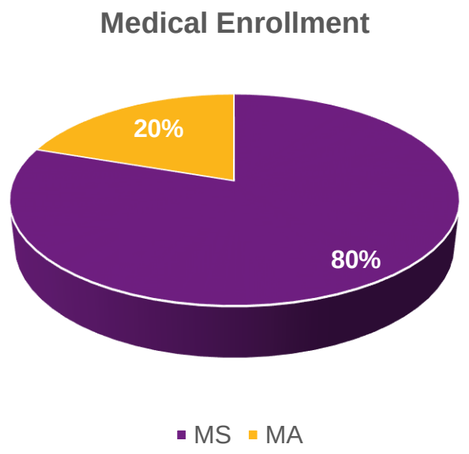
Health Reimbursement Arrangement:

- At the end of Q3 2019 there were 12,243 Health Reimbursement Arrangement (HRA) accounts for PEBP participants.
- There were 90,873 claims submitted against the HRA for reimbursement in Q3, with 76.9% being submitted via Auto-Reimbursement, meaning that participants did not have to manually submit 69,928 claims for Premium Reimbursement.
- The total reimbursement amount processed for Q2 was $10,959,822.

Summary of Retiree Decisions and Costs

Retiree Plan Selection Through 3/31/2019		Previous Qtr
Total enrolled through individual marketplace	12,731	12,812
Number of carriers**	100	99
Number of plans**	1,204	1,196

Plan Type Selection Through 3/31/2019		Previous Qtr
Medicare Advantage (MA, MAPD)	2,520	2,618
Medicare Supplement (MS)	10,212	10,222



"The percentage of Medicare Advantage plans selected by PEBP's retiree population is now slightly below the average for Willis Towers Watson's Book of Business.

Plan Type	Number Enrolled	Average Premium
Medicare Supplement	10.212	$147
Medicare Advantage (MA,MAPD)	2,520	$0 / $28
Part D drug coverage	8,527	$27
Dental coverage	1,155	$36
Vision coverage	1,866	$14

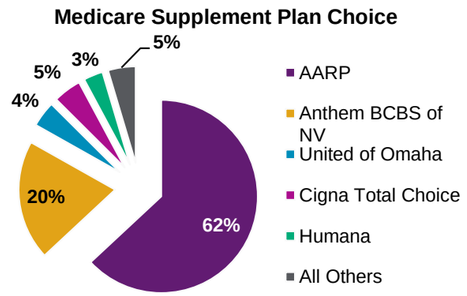
** Reflects total carriers and plans that PEBP participants have enrolled in nationwide, since inception.

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd Quarter Plan Year 2019

Summary of Retiree Carrier Choice

Top Medicare Supplement Plans	Total
AARP	6,373
Anthem BCBS of NV	2,036
United of Omaha	429
Cigna Total Choice	475
Humana	328

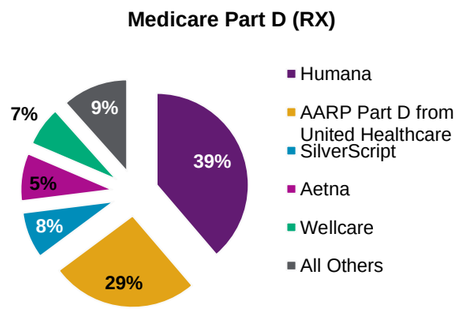


Cost Data For MS Plans	Cost
Minimum	$22
Average	$147
Median	$143
Maximum	$411

Top Medicare Advantage Plans	Total
Hometown Health Plan	1,321
Humana	375
AARP Medicare Advantage	253
Aetna	229
United Healthcare	67

Cost Data For MA Plans	Cost
Minimum	$0
Average	$28
Median	$0
Maximum	$223

Top Medicare Part D (RX)	Total
Humana	3,311
AARP Part D from United Healthcare	2,229
SilverScript	699
Aetna	749
WellCare	624



Cost Data For Part D (RX)	Cost
Minimum	$10
Average	$27
Median	$23
Maximum	$130

The Public Employees Benefit Program Executive Dashboard

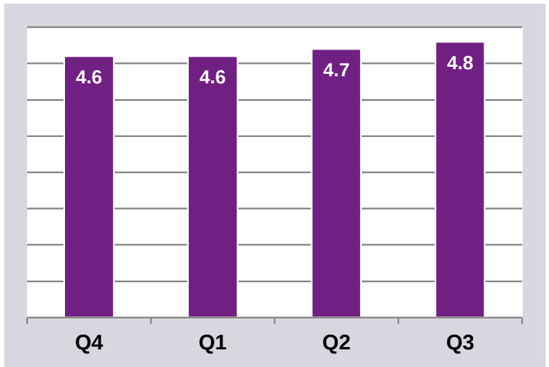
Quarterly Update – 3rd Quarter Plan Year 2019

Customer Service – Voice of the Customer (VoC)

Individual Marketplace conducts phone and email surveys of all participant transactions. Each survey contains approximately 12-16 questions. Responses are scanned by IBM Mindshare Analytics which expose trends within an hour, alerting Individual Marketplace of issues and allowing for real-time feedback and adjustments

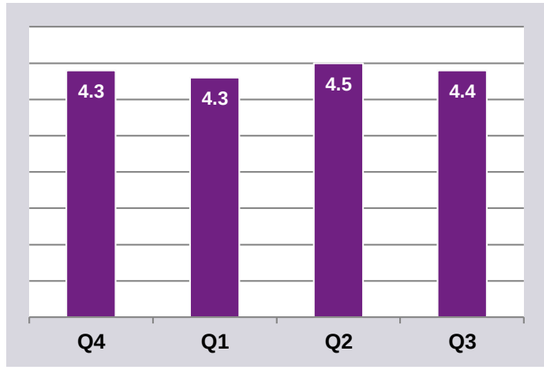
Q3 Enrollment Satisfaction

CSAT score	Count	%
5	49	84%
4	6	10%
3	2	3%
2	1	2%
1	0	0%
	58	**100%**



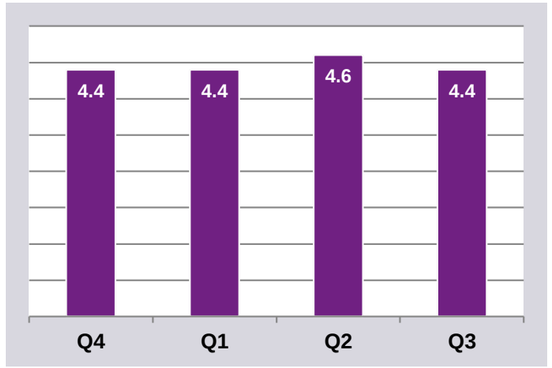
Q3 Service Satisfaction

CSAT score	Count	%
5	283	68%
4	65	16%
3	35	8%
2	18	4%
1	18	4%
	419	**100%**



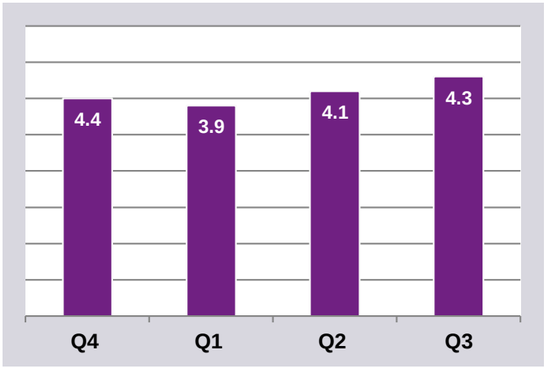
Q3 Enrollment & Service Combined

CSAT score	Count	%
5	332	70%
4	71	15%
3	37	8%
2	19	4%
1	18	4%
	477	**100%**



Q3 HRA Satisfaction

CSAT score	Count	%
5	93	64%
4	26	18%
3	12	8%
2	4	3%
1	11	8%
	146	**100%**

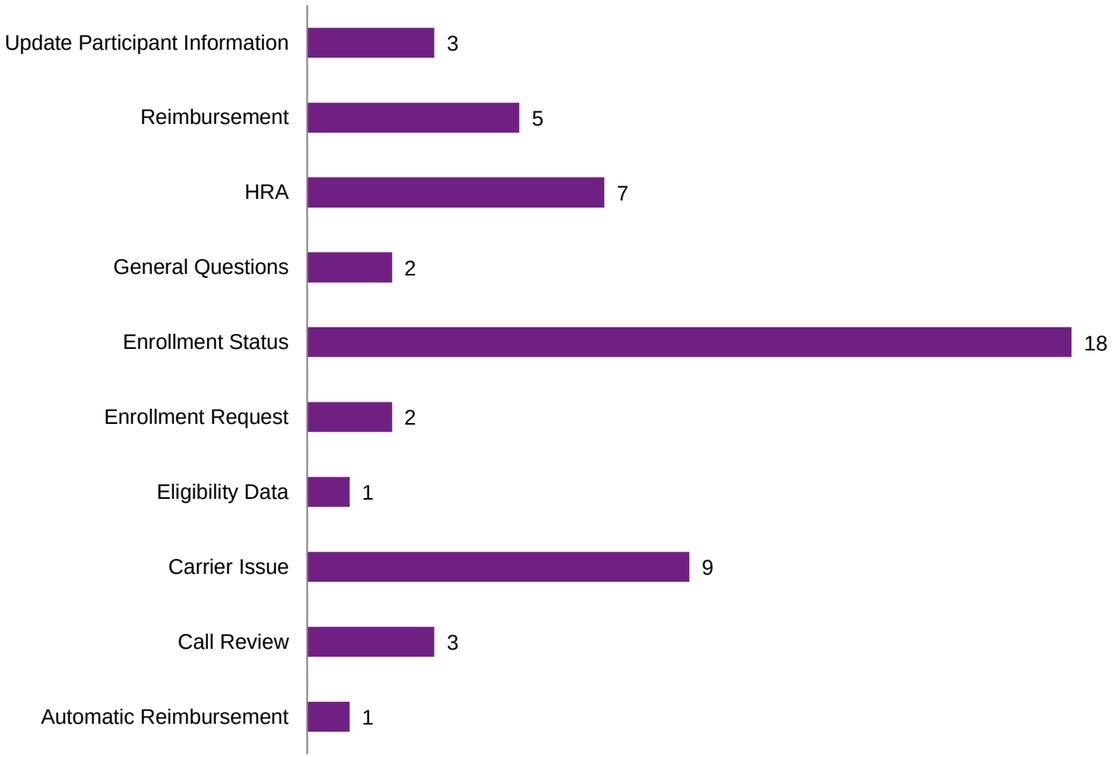


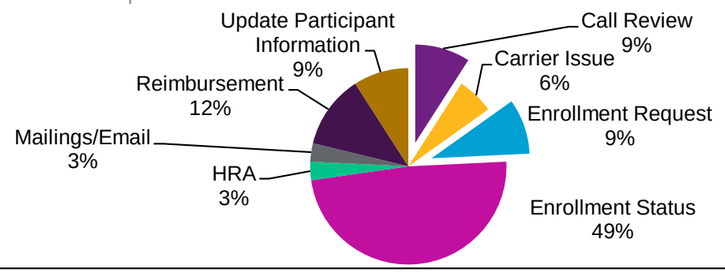
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd Quarter Plan Year 2019

Customer Service – Issues Log Resolution

Each quarter a certain number of participant inquiries are received by both PEBP and Willis Towers Watson that require escalation to Individual Marketplace Issues Log. Items on the Issues Log are carefully evaluated and continuously monitored by seasoned Willis Towers Watson staff until resolution is reached. The total number of inquiries reviewed during Q3-PY19 is 51 and are associated with the following categories:





Health Reimbursement Account (HRA)

Claim Activity for the Qtr.	Total
HRA accounts	12,243
Number of claims paid	85,443
Accounts with no balance	6,148
Claims paid amount	$10,959,822.83

Claims By Source	Total
A/R file	69,928
Mail	17,373
Web	3,572

Call Category	Total
General / Instructional	1,245
Other	195
Denial Reason Explanation	204
Autopay / Auto Reimbursement	17
Date EFT / Mail Issued	69

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd Quarter Plan Year 2019

Performance Guarantees*

Category	Commitment	Outcome	PG MET
Claims turnaround time	≤ 2 days	0.48 Days	Yes
Claim financial accuracy	≥ 98%	99.49%	Yes
Claim processing financial accuracy	≥ 98%	98.57%	Yes
HRA call center abandon rate	≤ 5%	0.89%	Yes
HRA customer service - avg. speed to answer	≤ 30 seconds	13 Seconds	Yes
Reports	≤ 10 business days	As Scheduled	Yes
HRA web services	≥ 99%	Uptime >99%	Yes
Benefits admin customer service avg. speed to answer Q3	≤ 5 minutes	14s	Yes

*Please note that the performance guarantees are ultimately measured based on the annual audit period.

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2019

Operations Report

Spring Retiree Meetings:

The Spring Retiree Meetings were held on March 12, March 14, and March 15 in Las Vegas, Carson City, and Reno. At each location there were two meetings per day with the morning meeting focusing on participants aging-in to Medicare and the afternoon meeting focusing on the HRA for those that are already Medicare eligible. The below chart includes information about the meeting attendance and additional comments. Overall attendance was larger than expected in all three locations.

Date	Location	Attendance	Comments
March 12	College of Southern Nevada North Las Vegas Campus C Building - Conference Room 2638 3200 E. Cheyenne Ave North Las Vegas, NV 89030	Age-in Meetings; 147 HRA Meetings: 49	Initial attendance for both meetings was greater than expected. We anticipated 50 attendees for the age-in meeting as last year the count was only 27 attendees.. The meeting room was not large enough to handle the attendees, so the age-in meeting was split in two. PEBP will book a larger capacity room for future retiree meetings.
March 14	Nevada Army National Guard Auditorium 2460 Fairview Dr. Carson City, NV 89701	Age-in Meetings; 123 HRA Meetings: 43	
March 15	Truckee Meadows Community College Sierra Building, Room 105 7000 Dandini Boulevard Reno, NV 89512	Age-in Meetings; 98 HRA Meetings: 33	

Fall Retiree Meetings

The Fall Retiree Meetings have been scheduled and will be held on October 9, October 10, and October 11 in Las Vegas, Carson City, and Reno. At each location there will two meetings per day with the morning meeting focusing on participants aging-in to Medicare and the afternoon meeting focusing on the HRA for those that are already Medicare eligible. The locations for the fall meetings are the same as listed above, however the room for the Las Vegas meeting has changed to the Horn Theatre.

The Public Employees Benefit Program Executive Dashboard

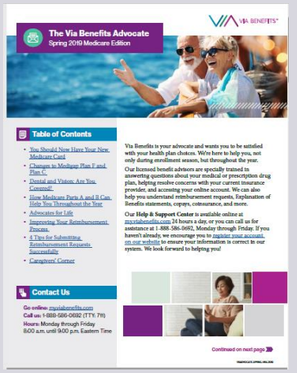
Quarterly Update – 2nd Quarter Plan Year 2019

Operations Report

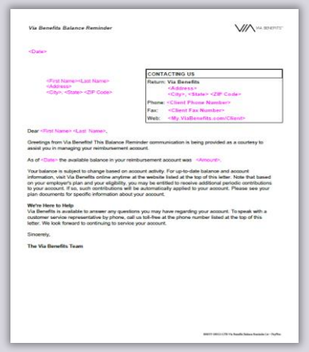
Communications:

Below is information on communications that are currently in process or will be coming up.

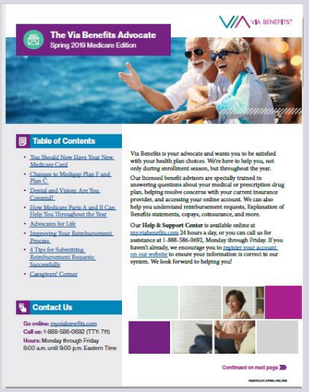
- Spring Newsletter
  - This communication is sent to participants via email and was sent the week of May 27. The intent of this communication is to educate participants on different areas like Medicare, HRA, Direct Deposit, and Auto-Reimbursement functionality.



- Fall Balance Reminder
  - This communication is sent to participants via mail. The communication will be sent in the September/October time period. The intent of this communication is to reminder participants of the balance in their HRA. It is only sent to those participants who have not had a claim reimbursement in the prior 90 days.



- Fall Newsletter
  - This communication is sent to participants via mail or email. It will be sent starting at the end of August through the end of September. The intent of this communication is to educate participants on different areas like Medicare, HRA, Direct Deposit, and Auto-Reimbursement functionality.



The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd Quarter Plan Year 2019

Nevada PEBP Historical Call Statistics

The below charts reflect the historical call statistics for Nevada PEBP for 2019.

Month	Average Wait Time	Total Calls	Abandoned Calls	Average Handle Time	Outreach Attempts
January	1m 10s	2,623	89	22m 17s	356
February	24s	1,732	11	22m 23s	160
March	14s	1,584	5	23m 24s	228
April	14s	1,602	6	24m 00s	230
May	15s	1,584	3	24m 41s	192
June	15s	1,461	4	26m 45s	198
July					
August					
September					
October					
November					
December					

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd Quarter Plan Year 2019

Nevada PEBP Historical Call Statistics

The below charts reflect the historical call statistics for Nevada PEBP for 2018.

Month	Average Wait Time	Total Calls	Abandoned Calls	Average Handle Time	Outreach Attempts
January	03m 32s	2,671	223	21m 39s	266
February	25s	1,890	8	18m 01s	318
March	22s	2,001	13	19m 03s	354
April	13s	1,750	7	21m 01s	170
May	14s	1,653	3	22m 45s	192
June	13s	1,615	8	23m 47s	329
July	16s	1,589	2	25m 18s	282
August	15s	1,379	0	26m 19s	224
September	15s	1,686	1	22m 56s	336
October	37s	2,484	36	29m 16s	357
November	33s	2,441	23	32m 10s	271
December	34s	2,241	24	25m 27s	322

4.5.

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

   Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

   4.5. Accept the Fiscal Year 2019 Other Post-Employment Benefits (OPEB) valuation prepared by Aon in conformance with the Governmental Accounting Standards Board (GASB) requirements.

Actuarial Report

State of Nevada Postretirement Health and Life Insurance Plan

GASB 75 Accounting Valuation for the Fiscal Year Ending June 30, 2019

Based on a July 1, 2018 Measurement Date

AON
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Contents

Introduction

This report documents the results of the actuarial valuation for the fiscal year ending June 30, 2019 of the Postretirement Health and Life Insurance Plan for the State of Nevada (the "State"). These results are based on a measurement date of June 30, 2018. The information provided in this report is intended strictly for documenting financial accounting disclosure and reporting requirements.

Determinations for purposes other than financial accounting disclosure and reporting requirements may be significantly different from the results in this report. Thus, the use of this report for purposes other than those expressed here may not be appropriate.

This valuation has been conducted in accordance with generally accepted actuarial principles and practices, including the applicable Actuarial Standards of Practice as issued by the Actuarial Standards Board. In addition, the valuation results are based on our understanding of the financial accounting and reporting requirements under U.S. Generally Accepted Accounting Principles as set forth in Governmental Accounting Standards Board Statement 75 (GASB 75) including any guidance or interpretations provided by the State and/or its audit partners prior to the issuance of this report. The information in this report is not intended to supersede or supplant the advice and interpretations of the State's auditors. Additional disclosures may be required under GASB 74.

Future actuarial measurements may differ significantly from the current measurements presented in this report due (but not limited to) to such factors as the following:

- Plan experience differing from that anticipated by the economic or demographic assumptions;
- Changes in actuarial methods or in economic or demographic assumptions;
- Increases or decreases expected as part of the natural operation of the methodology used for these measurements (such as the end of an amortization period); and
- Changes in plan provisions or applicable law.

Due to the limited scope of our assignment, we did not perform an analysis of the potential range of such future measurements.

Funded status measurements shown in this report are determined based on various measures of plan assets and liabilities. For financial accounting disclosure and reporting purposes, funded status is determined using plan assets measured at market value. Plan liabilities are measured based on the interest rates and other assumptions summarized in the Actuarial Assumptions and Methods section of this report. These funded status measurements may not be appropriate for assessing the sufficiency of plan assets to cover the estimated cost of settling the plan's benefit obligations, and funded status measurements for financial accounting disclosure and reporting purposes may not be appropriate for assessing the need for or the amount of future contributions.

In conducting the valuation, we have relied on personnel, plan design, and asset information supplied by the State. While we cannot verify the accuracy of all the information, the supplied information was reviewed for consistency and reasonableness. As a result of this review, we have no reason to doubt the substantial accuracy or completeness of the information and believe that it has produced appropriate results.

The actuarial assumptions and methods used in this valuation are described in the Actuarial Assumptions and Methods section of this report. The State selected the economic and demographic assumptions and

prescribed them for use for purposes of compliance with GASB 75. Aon provided guidance with respect to these assumptions, and it is our belief that the assumptions represent reasonable expectations of anticipated plan experience.

The undersigned are familiar with the near-term and long-term aspects of postemployment benefits and collectively meet the Qualification Standards of the American Academy of Actuaries necessary to render the actuarial opinions contained herein. The information provided in this report is dependent upon various factors as documented throughout this report, which may be subject to change. Each section of this report is considered to be an integral part of the actuarial opinions.

To our knowledge, no colleague of Aon providing services to the State has any material direct or indirect financial interest in the State. Thus, we believe there is no relationship existing that might affect our capacity to prepare and certify this actuarial report for the State.

Scott E. Syverson, EA, MAAA
Aon

Ronald J. Kalvoda, FSA, EA
Aon

Neal A. Holthus, FSA, EA
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Elizabeth A. Hanson, FSA, MAAA
Aon

June 2019

Summary

This report documents the results of the actuarial valuation for the State of Nevada Postretirement Health and Life Insurance Plan for the fiscal year ending June 30, 2019. The valuation results are based on the financial accounting and reporting requirements under GASB 75 and a July 1, 2018 measurement date.

This valuation includes retiree medical, prescription drug, dental and life insurance benefits. The valuation results reflect the plan provisions in effect as of January 1, 2018. It's our understanding there have been no significant plan changes since January 1, 2018. In addition, the valuation is based census data provided by the State as of January 1, 2018. Active employees hired after December 31, 2011 are not eligible for benefits and have been excluded from the valuation.

A nominal amount of assets, associated with the HRA benefit, have been accumulated in a trust by the State for purposes of paying future benefits. The amount of assets in the trust are less than the expected benefit payments in the first year. In addition, it is our understanding that the State intends to fund future benefits on a pay-as-you-go basis. Therefore, the discount rate used in the valuation is based on the Bond Buyer General Obligation 20-Bond Municipal Bond Index for all years, consistent with the requirements of GASB 75.

Plan Changes

There have been no plan changes since the prior valuation.

Assumption Changes

The valuation reflects the following assumption changes from the July 1, 2017 measurement date to the July 1, 2018 measurement date:

- Discount rate changed from 3.58% to 3.87%

Method Changes

There have been no method changes since the prior valuation.

Valuing Postretirement Medical Benefits

In reviewing these valuation results, it should be noted that determining the value of future health care benefits is especially difficult because assumptions must be made about future events that are difficult to predict. Future increases in health care costs are affected by many factors, including:

- Heath care inflation
- Changes in utilization patterns
- Technological advances
- Cost shifting (i.e., increase in private plans' costs in non-managed programs due to uninsured claims, changes in the Medicare payment structure, and increased emphasis on managed care programs)
- Cost leveraging (i.e., erosion of fixed deductibles and out of pocket maximums)
- Changes to government medical programs, such as Medicare

Changes, even small changes, in assumptions or actual experience can lead to significant changes in results. Due to the limited scope of our assignment, we did not perform an analysis of the potential range of such future measurements.

Estimating Current Health Care Costs

In addition to estimating future increases in health care claims costs, it is necessary to develop a starting claims cost on a per covered individual basis. For a discussion of the process used to develop claims and details on the health care trend and other assumptions used in this valuation, see the Health Care Claims Development and Actuarial Assumptions and Method sections of this report.

Accounting Requirements

Development of GASB 75 Net OPEB Expense

Calculation Details

The following table illustrates the Net OPEB Liability under GASB 75.

	Fiscal Year Ending 6/30/2018	Fiscal Year Ending 6/30/2019
▪ Total OPEB Liability		
– Retired Participants and Beneficiaries Receiving Payment	$ 744,952,000	$ 712,368,500
– Active Participants	557,912,500	613,611,300
– Total	$ 1,302,864,500	$ 1,325,979,800
▪ Plan Fiduciary Net Position	$ 1,476,200	$ 1,597,300
▪ Net OPEB Liability	$ 1,301,388,300	$ 1,324,382,500
▪ Plan Fiduciary Net Position as a Percentage of the Total OPEB Liability	0%	0%
▪ Deferred Outflow of Resources for Contributions Made After Measurement Date	$ 39,668,900	$ TBD

Expense

The following table illustrates the OPEB expense under GASB 75.

	Fiscal Year Ending 6/30/2019
▪ Service Cost	$ 51,881,500
▪ Interest Cost	47,795,300
▪ Expected Investment Return	(52,100)
▪ Contributions from Non-Employer Contributing Entities	0
▪ Administrative Expense	0
▪ Plan Changes	0
▪ Amortization of Unrecognized	
– Liability (Gain)/Loss	0
– Asset (Gain)/Loss	(47,500)
– Assumption Changes	(29,111,100)
▪ Total Expense	$ 70,466,100

Shown below are details regarding the calculation of Service Cost, Interest Cost, and Expected Investment Return components of the Expense.

		Fiscal Year Ending 6/30/2019
Development of Service Cost:		
▪ Normal Cost at Measurement Date		$ 51,881,500
Development of Interest Cost:		
▪ Total OPEB Liability at Measurement Date		$ 1,302,864,500
▪ Normal Cost at Measurement Date		51,881,500
▪ Benefit Payments, net of Employee Contributions		(39,710,200)
▪ Discount Rate	명	3.58%
▪ Interest Cost		$ 47,795,300
Development of Expected Investment Return:		
▪ Plan Fiduciary Net Position at Measurement Date		$ 1,476,200
▪ Employer Contributions		39,668,900
▪ Benefit Payments, net of Employee Contributions		(39,710,200)
▪ Administrative Expenses		0
▪ Expected Return on Assets		3.58%
▪ Expected Investment Return		$ 52,100

Reconciliation of Net OPEB Liability

Shown below are details regarding the Total OPEB Liability, Plan Fiduciary Net Position, and Net OPEB Liability for the period from June 30, 2018 to June 30, 2019.

	Fiscal Year Ending 6/30/2019		
	Total OPEB Liability	**Plan Fiduciary Net Position**	**Net OPEB Liability**
Balance Recognized at 6/30/2018 (Based on 7/1/2017 Measurement Date)	$ 1,302,864,500	$ 1,476,200	$ 1,301,388,300
Changes Recognized for the Fiscal Year:			
▪ Service Cost	51,881,500	N/A	51,881,500
▪ Interest on Total OPEB Liability	47,795,300	N/A	47,795,300
▪ Changes of Benefit Terms	0	N/A	0
▪ Differences Between Expected and Actual Experience	0	N/A	0
▪ Assumption Changes	(36,851,300)	N/A	(36,851,300)
▪ Benefit Payments, net of Employee Contributions	(39,710,200)	(39,710,200)	0
▪ Employer Contributions	N/A	39,668,900	(39,668,900)
▪ Net Investment Income	N/A	162,400	(162,400)
▪ Administrative Expense	N/A	0	0
Net Changes	23,115,300	121,100	22,994,200
Balance Recognized at 6/30/2019 (Based on 7/1/2018 Measurement Date)	$ 1,325,979,800	$ 1,597,300	$ 1,324,382,500

Sensitivity

The following table illustrates the impact of discount rate sensitivity on the Net OPEB Liability for fiscal year ending June 30, 2019:

	1% Decrease (2.87%)	**Discount Rate (3.87%)**	**1% Increase (4.87%)**
Total OPEB Liability	$ 1,460,832,500	$ 1,325,979,800	$ 1,208,782,300
Plan Fiduciary Net Position	1,597,300	1,597,300	1,597,300
Net OPEB Liability	$ 1,459,235,200	$ 1,324,382,500	$ 1,207,185,000

The following table illustrates the impact of health care trend rate sensitivity on the Net OPEB Liability for fiscal year ending June 30, 2019:

	1% Decrease	**Trend Rates**	**1% Increase**
Total OPEB Liability	$ 1,236,938,500	$ 1,325,979,800	$ 1,431,098,400
Plan Fiduciary Net Position	1,597,300	1,597,300	1,597,300
Net OPEB Liability	$ 1,235,341,200	$ 1,324,382,500	$ 1,429,501,100

Liability (Gain)/Loss

The following table illustrates the liability gain/loss under GASB 75.

	Fiscal Year Ending 6/30/2019
▪ OPEB Liability at Beginning of Measurement Period	$ 1,302,864,500
▪ Service Cost	51,881,500
▪ Interest on the Total OPEB Liability	47,795,300
▪ Changes of Benefit Terms	0
▪ Assumption Changes	(36,851,300)
▪ Benefit Payments, net of Employee Contributions	(39,710,200)
▪ Expected OPEB Liability at End of Measurement Period	$ 1,325,979,800
▪ Actual OPEB Liability at End of Measurement Period	1,325,979,800
▪ OPEB Liability (Gain)/Loss	$ 0
▪ Average Future Working Life Expectancy	4.78
▪ OPEB Liability (Gain)/Loss Amortization	$ 0
▪ Assumption Changes	$ (36,851,300)
▪ Average Future Working Life Expectancy	4.78
▪ Assumption Changes Amortization	$ (7,709,500)

Asset (Gain)/Loss

The following table illustrates the asset gain loss under GASB 75.

	Fiscal Year Ending 6/30/2019
▪ OPEB Asset at Beginning of Measurement Period	$ 1,476,200
▪ Employer Contributions	39,668,900
▪ Expected Investment Income	52,100
▪ Benefit Payments, net of Employee Contributions	(39,710,200)
▪ Administrative Expense	0
▪ Expected OPEB Asset at End of Measurement Period	$ 1,487,000
▪ Actual OPEB Asset at End of Measurement Period	1,597,300
▪ OPEB Asset (Gain)/Loss	$ (110,300)
▪ Amortization Factor	5.00
▪ OPEB Asset (Gain)/Loss Amortization	$ (22,100)

Deferred Outflows/Inflows

The following table illustrates the Deferred Inflows and Outflows at the end of the fiscal year under GASB 75.

	Deferred Outflows	Deferred Inflows
Difference Between Actual and Expected Experience		
▪ Measurement Date July 1, 2017	$ 0	$ 0
▪ Measurement Date July 1, 2018	$ 0	$ 0
Assumption Changes		
▪ Measurement Date July 1, 2017	$ 0	$ 59,496,300
▪ Measurement Date July 1, 2018	$ 0	$ 29,141,800
Net Difference Between Expected and Actual Earnings on OPEB Plan Investments		
▪ Measurement Date July 1, 2017	$ 0	$ 76,400
▪ Measurement Date July 1, 2018	$ 0	$ 88,200
Contribution Made in Fiscal Year Ending June 30, 2019	TBD	N/A
Total	$ 0	$ 88,802,700

Amortization of Deferred Inflows/Outflows

The table below lists the amortization bases included in the deferred inflows/outflows as of June 30, 2019.

Date Established	Type of Base	Period		Balance		Annual Payment
		Original	Remaining	Original	Remaining	
July 1, 2017	Liability (Gain)/Loss	4.78	2.78	$ 0	$ 0	$ 0
July 1, 2017	Assumption Changes	4.78	2.78	$ (102,299,500)	$ (59,496,300)	$ (21,401,600)
July 1, 2017	Asset (Gain)/Loss	5.00	3.00	$ (127,200)	$ (76,400)	$ (25,400)
July 1, 2018	Liability (Gain)/Loss	4.78	3.78	$ 0	$ 0	$ 0
July 1, 2018	Assumption Changes	4.78	3.78	$ (36,851,300)	$ (29,141,800)	$ (7,709,500)
July 1, 2018	Asset (Gain)/Loss	5.00	4.00	$ (110,300)	$ (88,200)	$ (22,100)
	Total Charges				$ (88,802,700)	$ (29,158,600)

Amounts Recognized in the deferred outflows of resources and deferred inflows of resources related to OPEB will be recognized in the OPEB expense as follows:

Year-End 6/30	
2020	$ (29,158,600)
2021	$ (29,158,600)
2022	$ (24,450,100)
2023	$ (6,035,400)
2024	$ 0

Supplemental Information

Changes in the Net OPEB Liability and Related Ratios

The follow exhibit is a 3-year history of change in Net OPEB Liability.

	Fiscal Year Ending June 30		
	2017	**2018**	**2019**
Total OPEB Liability			
▪ Service Cost	N/A	$ 59,309,600	$ 51,881,500
▪ Interest Cost	N/A	39,468,600	47,795,300
▪ Changes of Benefit Terms	N/A	0	0
▪ Differences Between Expected and Actual Experiences	N/A	0	0
▪ Changes of Assumptions	N/A	(102,299,500)	(36,851,300)
▪ Benefit Payments, net of Employee Contributions	N/A	(38,069,200)	(39,710,200)
▪ Net Change in Total OPEB Liability	N/A	$ (41,590,500)	$ 23,115,300
▪ Total OPEB Liability (Beginning)	N/A	$ 1,344,455,000	$ 1,302,864,500
▪ Total OPEB Liability (Ending)	N/A	$ 1,302,864,500	$ 1,325,979,800
Plan Fiduciary Net Position			
▪ Employer Contributions	N/A	$ 38,048,600	$ 39,668,900
▪ Net Investment Income	N/A	164,800	162,400
▪ Benefit Payments, net of Employee Contributions	N/A	(38,069,200)	(39,710,200)
▪ Administrative Expense	N/A	0	0
▪ Net Change in Plan Fiduciary Net Position	N/A	$ 144,300	$ 121,100
▪ Plan Fiduciary Net Position (Beginning)	N/A	$ 1,331,900	$ 1,476,200
▪ Plan Fiduciary Net Position (Ending)	N/A	$ 1,476,200	$ 1,597,300
▪ Net OPEB Liability (Ending)	N/A	$ 1,301,388,300	$ 1,324,382,500
▪ Net Position as a % of OPEB Liability	N/A	0%	0%
▪ Covered Payroll	N/A	$ 1,663,856,400	TBD
▪ Net OPEB Liability as a % of Payroll	N/A	78%	N/A

Contribution Schedule

The follow exhibit is a 3-year history of Contributions.

	Fiscal Year Ending June 30		
	2017	**2018**	**2019**
Actuarially Determined Contribution	N/A	N/A	N/A
Contributions Made in Relation to the Actuarially Determined Contribution	N/A	N/A	N/A
Contribution Deficiency (Excess)	N/A	N/A	N/A
Covered Employee Payroll	N/A	$ 1,663,856,400	TBD
Contributions as a % of Payroll	N/A	N/A	N/A

Notes to Schedule

Valuation Date	January 1, 2018

Methods and Assumptions used to Determine Contribution Rates

Actuarial Cost Method	Entry Age Normal Level % of Salary
Asset Valuation Method	Market Value of Assets
Retirement Rates	Varies by age and service
Mortality Rates	Regular: RP-2000 Combined Healthy Mortality projected to 2014 with Scale AA, set back one year for females Police/Fire: RP-2000 Combined Healthy Mortality projected to 2014 with Scale AA, set forward one year

Personnel Information

This actuarial valuation was based on personnel data supplied by the State as of January 1, 2018.

	January 1, 2018
Health Care Participants	
Active Participants[1]	
Number	13,190
Average Age	51.51
Average Service	14.41
Inactive Participants[2]	
State Retirees and Surviving Spouses Under Age 65	3,355
Average Age	59.36
State Retirees and Surviving Spouses Age 65 and Older	7,129
Average Age	73.69
Terminated Vested	2,272
Average Age	53.38
State Covered Spouses	2,067
Average Age	63.57
Total Participants	
Number	28,013
Life Insurance Participants	
Active Participants[1]	
Number	13,190
Average Age	51.51
Average Service	14.41
State Inactive Participants	
Number	12,375
Average Age	62.67
Non-State Inactive Participants	
Number	7,354
Average Age	68.15

[1] Active counts reflect those hired prior to January 1, 2012.
[2] Inactive counts include terminated vested participants.

Active Participants By Age and Service

The following table summarizes the distribution of the future retiree population by age and service as of January 1, 2018:

HTH ACTIVES
(AS OF JANUARY 1, 2018)

	COMPLETED YEARS OF SERVICE										
Age	**Under 1**	**1 to 4**	**5-10**	**10-14**	**15-19**	**20-24**	**25-29**	**30-34**	**35-39**	**40+**	**Total**
Under 25	0	0	0	0	0	0	0	0	0	0	0
25-29	0	0	8	2	0	0	0	0	0	0	10
30-34	0	0	53	27	2	0	0	0	0	0	82
35-39	0	0	63	80	14	2	0	0	0	0	159
40-44	0	0	68	88	64	12	0	0	0	0	232
45-49	0	0	74	140	93	58	14	0	0	0	379
50-54	0	0	111	107	82	72	22	5	0	0	399
55-59	0	0	82	137	91	59	32	0	1	0	402
60-64	0	0	72	103	65	34	15	6	2	0	297
65-69	0	0	27	28	20	14	12	2	1	0	104
70+	0	0	3	12	12	5	4	1	0	0	37
Total	0	0	561	724	443	256	99	14	4	0	2,101

HPN ACTIVES
(AS OF JANUARY 1, 2018)

	COMPLETED YEARS OF SERVICE										
Age	**Under 1**	**1 to 4**	**5-10**	**10-14**	**15-19**	**20-24**	**25-29**	**30-34**	**35-39**	**40+**	**Total**
Under 25	0	0	0	0	0	0	0	0	0	0	0
25-29	0	0	12	1	0	0	0	0	0	0	13
30-34	0	0	56	28	1	0	0	0	0	0	85
35-39	0	0	63	75	15	0	0	0	0	0	153
40-44	0	0	67	108	43	18	1	0	0	0	237
45-49	0	0	86	118	80	39	6	0	0	0	329
50-54	0	0	64	120	78	42	25	1	0	0	330
55-59	0	0	52	100	70	47	22	3	0	0	294
60-64	0	0	45	83	59	36	19	1	0	0	243
65-69	0	0	21	32	26	7	12	2	2	0	102
70+	0	0	7	9	9	10	6	2	2	1	46
Total	0	0	473	674	381	199	91	9	4	1	1,832

CDHP ACTIVES
(AS OF JANUARY 1, 2018)

	COMPLETED YEARS OF SERVICE										
Age	**Under 1**	**1 to 4**	**5-10**	**10-14**	**15-19**	**20-24**	**25-29**	**30-34**	**35-39**	**40+**	**Total**
Under 25	0	0	0	0	0	0	0	0	0	0	0
25-29	0	0	83	4	0	0	0	0	0	0	87
30-34	0	0	299	161	4	0	0	0	0	0	464
35-39	0	0	375	437	65	2	0	0	0	0	879
40-44	0	0	371	510	257	57	2	0	0	0	1,197
45-49	0	0	368	512	371	198	35	3	0	0	1,487
50-54	0	0	382	522	374	209	98	19	0	0	1,604
55-59	0	0	309	498	314	227	109	41	3	0	1,501
60-64	0	0	200	365	266	165	98	49	6	1	1,150
65-69	0	0	110	176	106	82	76	38	18	6	612
70+	0	0	26	68	58	37	29	23	16	19	276
Total	0	0	2,523	3,253	1,815	977	447	173	43	26	9,257

Plan Provisions

Eligibility

For a retiree to participate in the PEBP program, the participant must be receiving a PERS, LRS, JRS, or RPA benefit. PERS eligibility requirements vary by employee group and benefit type. Actives hired after December 31, 2011 are not eligible for any subsidy from PEBP. In addition, actives hired after December 31, 2009 and who retire with less than 15 years of continuous service (except a disability retirement) are not eligible for a subsidy from PEBP.

Normal Retirement—Regular Employees

- Minimum age of 65 with 5+ years of service
- Minimum age of 60 with 10+ years of service
- Minimum 30 years of service, regardless of age

Normal Retirement—Police & Fire Employees

- Minimum age of 65 with 5+ years of service
- Minimum age of 55 with 10+ years of service
- Minimum age of 50 and 20+ years of service
- Minimum 25 years of service, regardless of age

Disability Benefit

- Minimum 5 years of service, regardless of age

Reduced Benefit

- Minimum 5 years of service, regardless of age

For this valuation, Regular Employees were considered eligible for retirement at a minimum age of 50 with 5 years of service and Police & Fire Employees were considered eligible for retirement at a minimum age of 45 with 5 years of service.

Surviving spouses are not eligible to receive post-Medicare benefits.

Medical and Rx Benefits

- Pre-Medicare Retires

For retirees with younger spouses, retirees and spouses will move to the Exchange once the spouse becomes Medicare eligible (age 65). For retirees with older spouse, retirees and spouses will both move to the Exchange when the retiree becomes Medicare eligible.

- Medicare Retirees

Certain retirees over age 65 are not eligible for Medicare Part A as indicated on the data. For these participants, we have assumed they will not become eligible for Medicare Part A at any time in the future. Current active employees are assumed to be eligible for Medicare Part A. Medicare eligible retirees will go to the Exchange.

Medical and Rx Benefits ▪ Terminated Vesteds	If service is less than 10 years, Terminated Vested (TVs) participants are assumed to retire at age 65 and go directly to the Exchange. If service is ten years or more, TVs are assumed to retire at age 60 and move to the Exchange in the same manner as actives outlines above.
▪ Current Actives	Actives enrolled in the CDHP are assumed to participate in this plan upon retirement. It is assumed 5% of pre-Medicare actives enrolled in the HPN Plan will participate in the CDHP upon retirement. Likewise, it is assumed 20% of pre-Medicare actives enrolled in the HTH Plan will participate in the CDHP upon retirement. The balance of the HMO populations will remain in the HMO plan as early retirees. These assumptions were based upon actual PEBP census. For all plans, when actives retire and then reach age 65, it is assumed they become Medicare eligible. Once both the participant and spouse become Medicare eligible, it is assumed they will both participate in the Exchange.
Dental Benefits	Pre-Medicare retirees will participate in PEBP's Dental Plan. Those enrolled in the EHPD plan will assume to enroll in PEBP's dental plan. For those future Exchange retirees, we assume 55% will participate in PEBP's Dental program.
Life Insurance Benefits	If you participate in a PEBP medical plan, your benefits include $12,500 life insurance. Zero retiree contributions have been assumed for the life insurance. The life insurance retiree contribution for non-Medicare retirees is included in the medical premium. For Medicare retirees, the premium is paid by PEBP.
HRA Benefit	The following monthly amount will be credited on behalf of Medicare Eligible Retirees, effective July 1, 2016: ▪ For those who retired prior to January 1, 1994, the dollar amount is equal to $180 (previously was $165). ▪ For those who retired on or after January 1, 1994, the dollar amount is equal to the base amount ($12) multiplied by the years of service credit up to a maximum of 20 years of service. Prior to this plan year, the base amount was $11. ▪ A one-time contribution $2 per year of service per month for plan year 2016 and 2017.

Retiree Medical Contributions (Effective 7/1/2017-6/30/2018)

- State Non-Medicare Retirees and Survivors

	CDHP	HMO
Retiree	$ 209.08	$ 397.99
Retiree + Spouse	$ 477.86	$ 942.40
Surviving Spouse	$ 581.78	$ 802.75

- Non-State Non-Medicare Retirees and Survivors

	CDHP	HMO
Retiree	$ 391.67	$ 439.31
Retiree + Spouse	$ 953.23	$ 1,038.00
Surviving Spouse	$ 1,100.86	$ 868.57

- Voluntary Dental Rates for Medicare Exchange Retirees

	State	Non-State
Retiree	$ 38.89	$ 38.21
Retiree + Spouse	$ 77.78	$ 76.42
Surviving Spouse	$ 38.89	$ 38.21

Subsidy for Retires Enrolled in CDHP or HMO Plans

Years of Service	7/1/2016	7/1/2017
5	$ 322.72	$ 333.77
6	$ 290.45	$ 300.39
7	$ 258.18	$ 267.02
8	$ 225.91	$ 233.64
9	$ 193.63	$ 200.26
10	$ 161.36	$ 166.89
11	$ 129.09	$ 133.51
12	$ 96.82	$ 100.13
13	$ 64.54	$ 66.75
14	$ 32.27	$ 33.38
15	$ 0.00	$ 0.00
16	$ (32.27)	$ (33.38)
17	$ (64.54)	$ (66.75)
18	$ (96.82)	$ (100.13)
19	$ (129.09)	$ (133.51)
20	$ (161.36)	$ (166.89)

Part B Premium	The State of Nevada pays the Part B premium for eligible participants in the CDHP and HMO Plans. If not specifically indicated on the data, it is assumed any retiree over age 65 and participating in these plans will receive the Part B premium and the State pays the premium. For retirees indicated on the data file as eligible for Part B, it is assumed they will receive the Part B premium subsidy. The Part B premium subsidy in effect for 2018 calendar year is $134 per month.
Administrative Fees (Per Employee Basis)	Effective as of January 1, 2018 ▪ CDHP: $610.92 ▪ HMO: $269.04
HRA Account Reversions	▪ Pre-65 CDHP: 5.0% ▪ Medicare HRA: 0.5%

Health Care Claims Development

On March 23, 2010, the "Patient Protection and Affordable Care Act" was signed into law, followed by the passage of the "Health Care and Education Affordability Reconciliation Act of 2010" on March 30, 2010 ("Acts"). The health care reforms contained in these Acts have wide-spread impact on health care programs, including those covering retirees. This valuation reflects Aon's interpretation of the Acts based on information currently available. Future regulations on each aspect of the Acts may be different than Aon's initial interpretations.

Key issues in Health Care Reform that have an effect on the valuation include:

- Excise tax on high-cost health plans
- Group market reforms
- Early Retiree Reimbursement Program
- Taxation of Retiree Drug Subsidy for post-65 coverage

The valuation issues related to each of these topics are discussed below.

Excise Tax on High-Cost Health Plans

The excise tax on high cost plans becomes effective in 2022. However, the expected additional cost needs to be reflected in current valuations. Key features of the law include:

- Imposes a non-deductible excise tax of 40% on plans with an aggregate value of health insurance coverage exceeding specified dollar thresholds beginning in 2022
  - Aggregate value includes medical, pharmacy, and employer HSA/HRA contributions (excludes standalone dental and vision plans)
- 2018 thresholds for high-risk professions are:
  - $11,850 for single coverage and $30,950 for family coverage for age 55 to 64 retirees
  - $10,200 for single coverage and $27,500 for family coverage for Medicare retirees
- Thresholds will be increased if the increase in the cost of the Federal Employees Health Benefit Plan (FEHBP) increases by more than 55% from 2010 to 2018
  - Thresholds indexed at general inflation (CPI-U) plus 1 % from 2018 to 2019, and to CPI-U only thereafter
- Excise tax applies only to portion of cost that exceeds threshold amount
- The law provides for blending of pre-65 and post-65 retirees

The pre-65 and the post-65 retirees were blended together to determine the overall value of the benefit relative to the excise tax threshold. The values of the benefits were assumed to increase with the valuation trend and the excise tax thresholds were assumed to increase by 2.5% per year.

For purposes of determining the impact of excise tax on the State's Plan, the impact associated with the Medicare Exchange was determined separately from all other plans at the request of the State. As a result, the excise tax has no impact on the Medicare Exchange. The excise tax is anticipated to impact the non-Medicare Exchange plans in 2022. The estimated impact of the excise tax on the Total OPEB Liability is an increase of approximately 3.8%.

Health Care Claims Development

Group Market Reforms

- Requirement to Cover Children to Age 26
  - The Acts requires that a group health plan that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age. Current and future dependent children are valued implicitly in the valuation. Per capita claims costs were developed using claims information for all covered lives and adult headcounts. As such, the impact of child coverage is built into the per capita claims for retirees and spouses.
- Elimination of Benefit Limitations
  - The Acts include a number of other provisions that may increase the cost of retiree health care including the elimination of lifetime maximum benefits and "restrictive" annual benefit limitations. We have made no adjustment for these additional benefits because there are no material limits in the plans.

Medicare Part D reimbursements and the Early Retiree Reinsurance program do not fall under GASB 75.

Claims Cost Development

The first step in determining the liabilities under a postretirement welfare plan is to calculate the expected average claims cost per participant in the coming year. The preliminary per capita costs were developed as follows:

- For the CDHP plan, the per capita costs were based on the claims and enrollment for the time period January 1, 2015 – December 31, 2017, separately for state versus non-state. The experience was adjusted for demographics, historical plan design changes, rebates, and trended to the valuation period.
- For the HMO plans, the per capita rates were based on the July 2017 – June 2018 retiree premium rates provided for state versus non-state, and adjusted for trend and demographics.
- For the dental plan, the per capita costs were based on the claims and enrollment for the time period January 1, 2015 – December 31, 2017. The experience was trended to the valuation period. No aging was assumed.
- The final per capita costs for all the plans were based on a blend of the preliminary claim costs and the prior valuation's claim costs trended forward to the valuation period.

A sample of the resulting age related annual claims rates, including administrative expenses are shown below:

Health Care Claims Development

Health Care Claims as of January 1, 2018—CDHP Medical

	CDHP Medical			
	State		Non-State	
Age	Non-Medicare	Medicare	Non-Medicare	Medicare
30	$3,016	$3,016	$3,479	$3,479
31	$3,106	$3,106	$3,583	$3,583
32	$3,199	$3,199	$3,691	$3,691
33	$3,295	$3,295	$3,802	$3,802
34	$3,394	$3,394	$3,916	$3,916
35	$3,496	$3,496	$4,033	$4,033
36	$3,601	$3,601	$4,154	$4,154
37	$3,709	$3,709	$4,279	$4,279
38	$3,820	$3,820	$4,407	$4,407
39	$3,935	$3,935	$4,539	$4,539
40	$4,053	$4,053	$4,675	$4,675
41	$4,175	$4,175	$4,815	$4,815
42	$4,300	$4,300	$4,959	$4,959
43	$4,429	$4,429	$5,108	$5,108
44	$4,562	$4,562	$5,261	$5,261
45	$4,699	$4,699	$5,419	$5,419
46	$4,873	$4,873	$5,619	$5,619
47	$5,053	$5,053	$5,827	$5,827
48	$5,240	$5,240	$6,043	$6,043
49	$5,434	$5,434	$6,267	$6,267
50	$5,635	$5,635	$6,499	$6,499
51	$5,872	$5,872	$6,772	$6,772
52	$6,119	$6,119	$7,056	$7,056
53	$6,376	$6,376	$7,352	$7,352
54	$6,644	$6,644	$7,661	$7,661
55	$6,923	$6,923	$7,983	$7,983
56	$7,228	$7,228	$8,334	$8,334
57	$7,546	$7,546	$8,701	$8,701
58	$7,878	$7,878	$9,084	$9,084
59	$8,225	$8,225	$9,484	$9,484
60	$8,587	$8,587	$9,901	$9,901
61	$8,905	$8,905	$10,267	$10,267
62	$9,234	$9,234	$10,647	$10,647
63	$9,576	$9,576	$11,041	$11,041
64	$9,930	$9,930	$11,450	$11,450
65	$10,297	$3,604	$11,874	$4,156
66	$10,575	$3,701	$12,195	$4,268
67	$10,861	$3,801	$12,524	$4,383
68	$11,154	$3,904	$12,862	$4,502
69	$11,455	$4,009	$13,209	$4,623
70	$11,764	$4,117	$13,566	$4,748
71	$11,976	$4,192	$13,810	$4,834
72	$12,192	$4,267	$14,059	$4,921
73	$12,411	$4,344	$14,312	$5,009
74	$12,634	$4,422	$14,570	$5,100
75	$12,861	$4,501	$14,832	$5,191

Health Care Claims Development

Health Care Claims as of January 1, 2018—CDHP Rx

	CDHP Rx			
	State		Non-State	
Age	Non-Medicare	Medicare	Non-Medicare	Medicare
30	$652	$652	$599	$599
31	$683	$683	$628	$628
32	$716	$716	$658	$658
33	$750	$750	$690	$690
34	$786	$786	$723	$723
35	$824	$824	$758	$758
36	$864	$864	$794	$794
37	$905	$905	$832	$832
38	$948	$948	$872	$872
39	$993	$993	$914	$914
40	$1,041	$1,041	$958	$958
41	$1,091	$1,091	$1,004	$1,004
42	$1,143	$1,143	$1,052	$1,052
43	$1,198	$1,198	$1,103	$1,103
44	$1,255	$1,255	$1,156	$1,156
45	$1,315	$1,315	$1,211	$1,211
46	$1,377	$1,377	$1,268	$1,268
47	$1,442	$1,442	$1,328	$1,328
48	$1,510	$1,510	$1,390	$1,390
49	$1,581	$1,581	$1,455	$1,455
50	$1,655	$1,655	$1,523	$1,523
51	$1,733	$1,733	$1,595	$1,595
52	$1,814	$1,814	$1,670	$1,670
53	$1,899	$1,899	$1,748	$1,748
54	$1,988	$1,988	$1,830	$1,830
55	$2,081	$2,081	$1,916	$1,916
56	$2,177	$2,177	$2,004	$2,004
57	$2,277	$2,277	$2,096	$2,096
58	$2,382	$2,382	$2,192	$2,192
59	$2,492	$2,492	$2,293	$2,293
60	$2,607	$2,607	$2,399	$2,399
61	$2,727	$2,727	$2,509	$2,509
62	$2,853	$2,853	$2,624	$2,624
63	$2,984	$2,984	$2,745	$2,745
64	$3,121	$3,121	$2,871	$2,871
65	$3,265	$3,265	$3,003	$3,003
66	$3,389	$3,389	$3,117	$3,117
67	$3,518	$3,518	$3,235	$3,235
68	$3,652	$3,652	$3,358	$3,358
69	$3,791	$3,791	$3,486	$3,486
70	$3,935	$3,935	$3,618	$3,618
71	$4,033	$4,033	$3,708	$3,708
72	$4,134	$4,134	$3,801	$3,801
73	$4,237	$4,237	$3,896	$3,896
74	$4,343	$4,343	$3,993	$3,993
75	$4,452	$4,452	$4,093	$4,093

Health Care Claims Development

Health Care Claims as of January 1, 2018—HMO

	HMO			
	State		Non-State	
Age	Non-Medicare	Medicare	Non-Medicare	Medicare
30	$3,723	$3,723	$3,727	$3,727
31	$3,835	$3,835	$3,839	$3,839
32	$3,950	$3,950	$3,954	$3,954
33	$4,069	$4,069	$4,073	$4,073
34	$4,191	$4,191	$4,195	$4,195
35	$4,317	$4,317	$4,321	$4,321
36	$4,446	$4,446	$4,451	$4,451
37	$4,579	$4,579	$4,585	$4,585
38	$4,716	$4,716	$4,723	$4,723
39	$4,857	$4,857	$4,865	$4,865
40	$5,003	$5,003	$5,011	$5,011
41	$5,153	$5,153	$5,161	$5,161
42	$5,308	$5,308	$5,316	$5,316
43	$5,467	$5,467	$5,475	$5,475
44	$5,631	$5,631	$5,639	$5,639
45	$5,800	$5,800	$5,808	$5,808
46	$6,015	$6,015	$6,023	$6,023
47	$6,238	$6,238	$6,246	$6,246
48	$6,469	$6,469	$6,477	$6,477
49	$6,708	$6,708	$6,717	$6,717
50	$6,956	$6,956	$6,966	$6,966
51	$7,248	$7,248	$7,259	$7,259
52	$7,552	$7,552	$7,564	$7,564
53	$7,869	$7,869	$7,882	$7,882
54	$8,200	$8,200	$8,213	$8,213
55	$8,544	$8,544	$8,558	$8,558
56	$8,920	$8,920	$8,935	$8,935
57	$9,313	$9,313	$9,328	$9,328
58	$9,723	$9,723	$9,738	$9,738
59	$10,151	$10,151	$10,166	$10,166
60	$10,598	$10,598	$10,613	$10,613
61	$10,990	$10,990	$11,006	$11,006
62	$11,397	$11,397	$11,413	$11,413
63	$11,819	$11,819	$11,835	$11,835
64	$12,256	$12,256	$12,273	$12,273
65	$12,709	$4,448	$12,727	$4,454
66	$13,052	$4,568	$13,071	$4,575
67	$13,404	$4,691	$13,424	$4,698
68	$13,766	$4,818	$13,786	$4,825
69	$14,138	$4,948	$14,158	$4,955
70	$14,520	$5,082	$14,540	$5,089
71	$14,781	$5,173	$14,802	$5,181
72	$15,047	$5,266	$15,068	$5,274
73	$15,318	$5,361	$15,339	$5,369
74	$15,594	$5,458	$15,615	$5,465
75	$15,875	$5,556	$15,896	$5,564

Health Care Claims Development

Dental Claims as of January 1, 2018

	Gross Claims
Pre-65	$ 533
Post-65	$ 533

Age Grading Factors

Age	Medical	Rx
Under 44	3.0%	4.8%
45–49	3.7%	4.7%
50–54	4.2%	4.7%
55–59	4.4%	4.6%
60–64	3.7%	4.6%
65–69	2.7%	3.8%
70–74	1.8%	2.5%
75–79	2.2%	0.8%
80–84	2.8%	0.2%
85–89	1.4%	0.1%
90 and Over	0.0%	0.0%

Actuarial Assumptions and Methods

The actuarial assumptions and methods used in the June 30, 2019 valuation are stated below.

Valuation Date	January 1, 2018
Census Date	January 1, 2018
Measurement Date	July 1, 2018
Actuarial Method	Entry Age Normal Level % of Pay
Inflation (CPI)	2.50%
Discount Rate	Based on Bond Buyer General Obligation 20-Bond Municipal Bond Index: ▪ Measurement Date June 30, 2017: 3.58% ▪ Measurement Date June 30, 2018: 3.87%

Health Care Trend Rates

- Medical, Rx and Administrative Fees

Year	Trend
2017	6.50%
2018	7.50%
2019	7.00%
2020	6.50%
2021	6.00%
2022	5.50%
2023	5.25%
2024	5.00%
2025	4.75%
2026+	4.50%

- Dental 4.00%
- HRA Accounts 0.00%
- Part B Premiums 4.50%

Life Insurance Administrative Load 10.00%

Actuarial Assumptions and Methods

Health Benefits Participation	90% of current eligible actives and 60% of current terminated vested employees will elect retiree plan coverage. Additionally, 60% of future retirees who have declined coverage are assumed to elect to participate in the plan upon retirement. 60% of actives decremented to withdrawal from the plan with at least five years of service will elect retiree medical and dental coverage.
Life Insurance Participation	All active employees and current retirees that elected healthcare coverage. Reinstated retirees and survivors are not eligible to receive the life insurance benefit.
Plan Election Percentage	Future retiree election percentage is based on the current retiree plan enrollment distribution.
Demographic Assumptions	Census data was provided by the State and adjustments were made for missing data, which have an insignificant effect on the liability. The census provided did not include gender for every terminated vested participant, so it was assumed that the percentage of males among the terminated vested population is consistent with the percentage of males among the retiree population. All actives are assumed to accumulate State service only. A factor has been applied to total service for State and Non-State retirees which represents the percentage of a retiree's total service that is attributable to service with the State: ▪ State: 94% ▪ Non-State Retiree: 13%
Spouse Age Difference & Marriage Percentage	Male participants are assumed to be four years older than spouses; female participants are assumed to be two years younger than spouses. 30% of active males and 15% of active females will elect retiree spouse coverage.

Actuarial Assumptions and Methods

Healthy Mortality

- Regular: RP-2000 Combined Healthy Mortality projected to 2014 with Scale AA, set back one year for females.
- Police / Fire: RP-2000 Combined Healthy Mortality projected to 2014 with Scale AA, set forward one year.

Disabled Mortality: RP-2000 Disabled Retiree Mortality projected to 2014 with Scale AA, set forward three years.

Retirement Rates: See Table A.

Withdrawal Rates: See Table B.

Disability Rates: See Table C.

Salary Scale

- Inflation: 2.75%
- Productivity Pay Increases: 0.50%
- Promotional and Merit Salary Increase

Years of Service	Regular	Police & Fire
Under 1	5.90%	10.65%
1	4.80%	7.15%
2	4.00%	5.20%
3	3.60%	4.60%
4	3.30%	4.30%
5	3.00%	4.15%
6	2.80%	3.90%
7	2.70%	3.50%
8	2.50%	3.15%
9	2.35%	2.90%
10	2.15%	2.50%
11	1.75%	1.90%
12	1.50%	1.50%
13	1.25%	1.30%
14	1.10%	1.30%
15+	1.00%	1.30%

Actuarial Assumptions and Methods

Table A—Retirement Rates

	Regular Years of Service (%)				
Age	**5 - 9**	**10 - 19**	**20 - 24**	**25 - 29**	**30+**
45 - 49	0.00	0.00	1.00	7.00	20.00
50 - 54	1.00	2.00	2.00	10.00	20.00
55 - 59	2.00	4.00	6.00	13.00	25.00
60 - 61	8.00	12.00	18.00	25.00	25.00
62 - 64	10.00	14.00	18.00	25.00	25.00
65 - 69	20.00	20.00	22.00	25.00	25.00
70 - 74	40.00	40.00	60.00	60.00	60.00
75+	100.00	100.00	100.00	100.00	100.00

	Police / Fire Years of Service (%)				
Age	**5 - 9**	**10 - 19**	**20 - 24**	**25 - 29**	**30+**
Under 40	0.00	0.00	0.00	0.00	0.00
40 - 44	0.00	0.75	3.00	0.00	0.00
45 - 49	0.00	1.00	5.00	15.00	15.00
50 - 54	1.50	5.00	13.00	18.00	27.00
55 - 59	3.50	11.00	20.00	25.00	35.00
60 - 64	10.00	18.00	25.00	32.00	35.00
65 - 69	60.00	60.00	65.00	70.00	70.00
70+	100.00	100.00	100.00	100.00	100.00

Actuarial Assumptions and Methods

Table B—Withdrawal Rates

Years of Service	% Regular	% Police / Fire
0 - 1	16.50	14.00
1 - 2	12.50	6.50
2 - 3	9.70	5.75
3 - 4	7.30	4.75
4 - 5	6.60	4.25
5 - 6	5.00	3.50
6 - 7	4.00	3.00
7 - 8	3.50	2.25
8 - 9	3.25	1.90
9 - 10	3.00	1.75
10 - 11	2.75	1.50
11 - 12	2.50	1.25
12 - 13	2.25	1.00
13 - 14	2.00	0.90
14 - 15	1.75	0.80
15+	1.50	0.50

Actuarial Assumptions and Methods

Table C—Disability Rates

Age	% Regular	% Police / Fire
20 - 24	0.01	0.00
25 - 29	0.02	0.06
30 - 34	0.06	0.10
35 - 39	0.09	0.18
40 - 44	0.21	0.35
45 - 49	0.35	0.56
50 - 54	0.57	0.75
55 - 59	0.75	0.50
60 - 64	0.40	0.50
65+	0.00	0.00

5.

5. Health Claim Auditors, Inc. quarterly audit of HealthSCOPE Benefits for the timeframe January 1, 2019 – March 31, 2019: (1) Report from Health Claim Auditors; (2) HealthSCOPE Benefits response to audit report; and (3) for possible action to accept audit report findings and assess penalties, if applicable, in accordance with the performance guarantees included in the contract pursuant to the recommendation of Health Claim Auditors. (**For Possible Action**)

Claims and System Audit Report

for

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

Audit Period: PEBP Plan Year 2019, Quarter Three
January, February and March 2019

Audited Vendor:

HealthSCOPE BENEFITS

Healthy People
Healthy Business
Healthy Futures

Submitted By:
Health Claim Auditors, Inc.
April 2019

TABLE OF CONTENTS

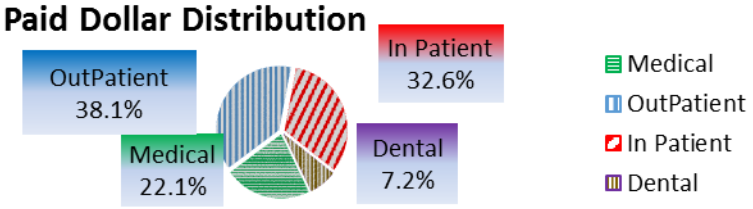
The following categories are reviewed each quarterly audit, however, because of their constant properties, the detail of each category will only be displayed within the first quarter audit of the PEBP fiscal year unless a change or defect is detected:

*HSB System	*HSB Policy/Procedure
*Eligibility	*Deductibles, Benefit Maximums
*Unbundling/Rebundling	*Concurrent Care
*Code Creeping	*Procedure, Diagnosis, Place of Service
*Experimental/Cosmetic Proc	*Medical Necessity Guidelines
*Patterns of Care	*Mandatory Outpatient/Inpatient Procedures
*Duplicate Claim Edits	*Adjusted Claims
*Hospital Discounts	*Hospital Bills and Audits
*Filing Limitation	*Unprocessed Claim Procedures
*R&C/Maximum Allowance	*Membership Procedures
*COBRA	*Provider Credentialing
*Coordination of Benefits	*Medicare
*Controlling Possible Fraud	*Security Access
*Quality Control/Internal Audit	*Internet Capabilities
*Communication, U/R and Claims Depts.	
*Claim Repricing	*Banking and Cash Flow
*Reporting Capabilities	*General System

EXECUTIVE SUMMARY

Audited Random Selection Data

Total number of claims: 500
Total Charge Value of random selection: $ 861,484.92
Total Paid Value of random selection: $ 273,007.02



Performance Guaranteed Metric Results

Metric	Guarantee Measurement	Actual	Pass/Fail
Payment Accuracy	≥ 98% of claims audited are to be paid accurately	98.4%	Pass
Financial Accuracy	≥ 99% of the dollars paid for the audited claims is to be paid accurately	98.31%	Fail
Claim Processing Turnaround Time	- 99% of all claims are to be processed within 30 days.	99.6%	Pass
Customer Service	-Telephone Response Time: ≤ 30 seconds. -Telephone Abandonment Rate: ≤ 2%. -First Call Resolution: ≥ 95%	14 sec. 1.21% 95.9%	Pass Pass Pass
Data Reporting	-100% of standard reports w/in 10 bus. days -Annual/Regulatory Documents w/in 10 business days of Plan Year end	No Exceptions Noted	Pass
Disclosure of Subcontractors	-Report access of PEBP data within 30 c. days -Removal of PEBP member PHI within 3 business days after knowledge	No Exceptions Noted	Pass

The following notations within the Executive Summary section are reported as follow up to previous findings and/or issues considered as an "outlier" of findings typically detected within the PEBP quarterly audits which require attention and/or acknowledgement for possible action(s).

Previous Recommendation(s)

HCA is pleased to report that all previous recommendations accepted by the PEBP Board of Directors has been implemented and/or in the process of application.

Previous Findings

End Stage Renal Disease

Previous detected an issue concerning errors with the payment of participant claims with diagnosis (DX) of End Stage Renal Disease (ESRD) where claims were found to be Medicare eligible and requesting in excess of $450,000 in overpayments. HCA has conducted follow-up focus audits and verified that the majority of these overpayments have been collected. HCA recommends that PEBP consider language within the Plan Specific Plan Document (SPD) that addresses the enrollment of participants Medicare eligible with an ESRD DX.

Current/Updated Findings

1) **Letters of Authorizations**

HTH contracting department may have some excluded services within their contracts that could be covered under "blanket" Letter of Authorizations (LOAs) that the claims repricing personnel and HSB are not provided.

This audit detected claims in which it was discovered that HTH has negotiated rates documented with LOAs for provider service(s) that would normally be edited as denied or inclusive and paid at $0 (i.e. CPT 99070, supplies and materials). Providers with rendered services under this circumstance are requesting that PEBP pay for said services as they are listed on their negotiated contract(s) and have been denied by HSB within their normal adjudication processes. It is HCA's recommendation that PEBP support the HSB system adjudication edits as they are universally accepted within the industry. Providers that are entitled to payment(s) for services within denied or inclusive codes will need to correctly recode said services for proper reimbursement(s). It is also HCA's recommendation, that HTH document negotiated rates for PEBP claims within a contract versus a LOA.

2) **Repricing by Hometown Health**

Audits have detected a trend in which the allowable rates repriced by Hometown Health and provided to HSB for adjudication of PPO claims are incorrect. Examples of this audit include claims repriced as "NON PPO" causing HSB to apply Usual & Customary (U&C) rates. Other examples are hospital claims with surgical services where the surgical add-on allowable is not applied as per contract agreement.

Trends/Issues

The audit revealed the following issues or trends detected from the random selection and bias selected claims. Please note: the reference numbers in **bold type** are claims from the random selection and are included within the statistical calculations. Reference numbers in normal type were identified as issues in bias claims as defined earlier and are not included within the statistical calculations of this audit. Specific information regarding supporting reference numbers can be found in the Audit Results Section in numerical sequence, which begins on page 15.

Incorrect rate due to network re-pricing;
Supporting reference nos. 005, 232, 242 and 260

Incorrect rate; Supporting reference nos. **082,** 495 and 505

Copay not applied; Supporting reference nos. **105, 149** and **328**

Copay applied in error; Supporting reference no. **032**

Incorrect copay applied; Supporting reference no. **114**

Claim paid at incorrect coinsurance; Supporting reference no. **219**

Incorrect calculation of payment on adjustment;
Supporting reference no. **414**

The audit revealed the following issues, which appear to be administered properly by HSB but should be brought to client attention for proper notification or verification. Specific information regarding supporting reference numbers can be found in the Audit Results Section in numerical sequence, which begins on page 15.

Programming issue with Quest Labs not being allowed under SHO contract; Supporting reference no. 229

Final clarification for 2018 Valley Health System contract percentage change received 10/18/18; Supporting reference no. 307

Accessories for denied DME not also denied;
Supporting reference no. 220

CLAIM PROCEDURES/SYSTEM CAPABILITIES/SUPPORT DATA

Introduction

In April 2019, Health Claim Auditors, Inc. (HCA) performed a Claims and System Audit of HealthSCOPE Benefits (HealthSCOPE) located in Little Rock, Arkansas on behalf of The State of Nevada Public Employees' Benefits Program (PEBP).

This audit was performed by collecting information to assure that HealthSCOPE is doing an effective job of controlling claim costs while paying claims accurately within a reasonable period of time. This report was presented to HealthSCOPE for any additional comments and responses on 25 April 2019.

Breakdown of Claims Audited

The individual claims audited were randomly selected from PEBP's claims listings as supplied by HealthSCOPE. These claims had dates of service ranging from January 2018 to March 2019 and were processed by HealthSCOPE from 01 January 2019 through 31 March 2019 (PEBP's Third Quarter Plan Year 2019). These claims were stratified by dollar volume to assure that HCA audited all types of claims. The audit also includes large dollar paid amounts that are considered as bias* selected claims.

*Bias claims are not part of the random selection but were audited by HCA because of some "out of the ordinary" characteristic of the claim. There are multiple criteria to identify the "out of the ordinary" characteristics. Examples are duplicates, CPT up coding, exceeding benefit limits, etc.

The breakdown of the 500 random selected claims audited is as follows:

Type of Service	Charge Amount	Paid Amount	Paid Distribution	No. of Claims
Medical	$ 191,534.01	$ 60,395.70	22.1%	332
Outpt. Hospital	$ 336,334.11	$ 104,063.61	38.1%	67
Inpt. Hospital	$ 298,357.45	$ 88,864.91	32.6%	5
Dental	$ 35,259.35	$ 19,682.80	7.2%	96
TOTAL	**$ 861,484.92**	**$ 273,007.02**	**100%**	**500**

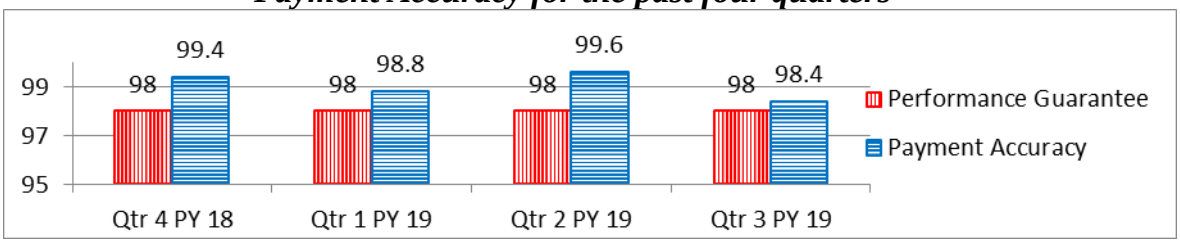
Payment Accuracy

Per PEBP, the Service Performance Standards and Financial Guarantees Agreement for the payment accuracy is to be 98% or above of claims adjudicated are to be paid correctly or a penalty of 2.5% of Quarterly Administration Fees for each percentage (%) point, or fraction thereof, below performance guarantee is to be applied. Payment Accuracy is calculated by dividing the total number of claims not containing payment errors in the audit period by the number of claims audited within the random selection.

The Payment Accuracy Percentage of the number of claims paid correctly from the HealthSCOPE random selection for this audited quarter is 98.2%.

Number of claims:	500
Number of claims paid incorrectly:	8
Percentage of claims paid incorrectly:	1.60%
Number of claims paid correctly:	492
Percentage of claims paid correctly:	98.40%

Payment Accuracy for the past four quarters



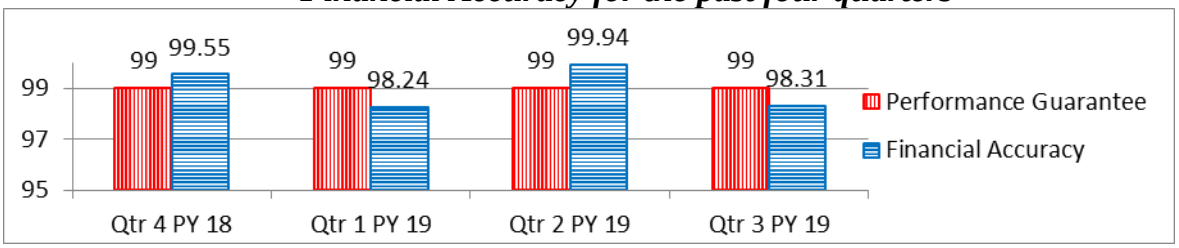
Financial Accuracy

Per PEBP, the Service Performance Standards and Financial Guarantees Agreement for the financial accuracy of the total dollars paid for claims adjudicated is to be paid correctly at 99% or above or a penalty of 2.5% of Quarterly Administration Fees for each percentage (%) point, or fraction thereof, below performance guarantee is to be applied. Financial Accuracy is calculated by dividing the total audited dollars paid correctly by the total audited dollars processed within the random selection.

The Financial Accuracy Percentage of paid dollars remitted correctly on the HealthSCOPE claims selected randomly for this audited quarter is 98.31%. This audit reflected seventy-two and five tenths percent (72.5%) of the audited errors within the valid random selection were overpayments.

Paid dollars audited	$ 273,007.02
Amount of paid dollars remitted incorrectly	$ 4,618.10
Percentage of Dollars paid incorrectly	1.69%
Paid Dollars of claims paid correctly	$ 268,388.92
Percentage of Dollars Paid correctly	98.31%

Financial Accuracy for the past four quarters



Historical Statistical Data of Performance Guarantees

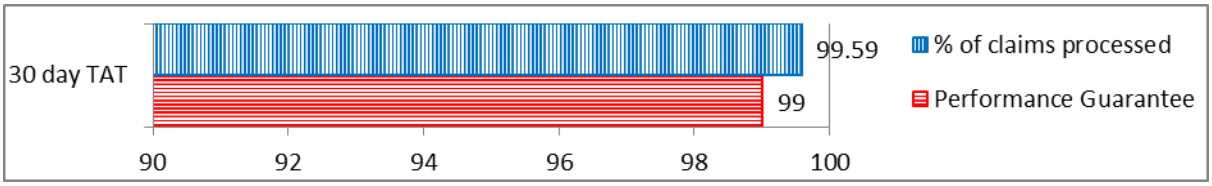
The following reflects the historical statistical data since the origin of PEBP medical claims administration by HealthSCOPE. The entries designated in **bold red type** are measurable categories with underperformance of the Service Performance Guarantees Agreement.

Period Audited	Payment Accuracy	Financial Accuracy	Turnaround Time	Telephone Response	Telephone Abandon Rate	First Call Resolution
1st Qtr PY 2012	95.7%	98.6%	7.6 days	:17	1.43%	N/A
2nd Qtr PY 2012	**93.3%**	**97.3%**	12.7 days	:12	1.16%	N/A
3rd Qtr PY 2012	**96.8%**	**98.6%**	3.7 days	:18	1.32%	N/A
4th Qtr PY 2012	**95.8%**	99.5%	11.4 days	:14	0.93%	N/A
1st Qtr PY 2013	97.2%	99.4%	10.4 days	:20	1.06%	N/A
2nd Qtr PY 2013	98.5%	99.3%	7.3 days	:11	0.87%	N/A
3rd Qtr PY 2013	98.0%	**95.7%**	6.4 days	:25	1.98%	N/A
4th Qtr PY 2013	98.4%	99.7%	6.2 days	:29	1.61%	N/A
1st Qtr PY 2014	98.8%	99.6%	5.4 days	:14	0.84%	N/A
2nd Qtr PY 2014	99.2%	99.2%	5.9 days	:29	1.96%	N/A
3rd Qtr PY 2014	98.0%	**98.5%**	5.2 days	**:30.5**	1.92%	N/A
4th Qtr PY 2014	99.0%	99.8%	4.4 days	:28	1.96%	N/A
1st Qtr PY 2015	98.8%	99.27%	4.9 days	:29.4	1.94%	N/A
2nd Qtr PY 2015	99.0%	99.35%	8.1 days	:22	1.18%	N/A
3rd Qtr PY 2015	98.6%	99.8%	5.9 days	:29.7	1.97%	N/A
4th Qtr PY 2015	99.6%	**95.6%**	4.9 days	:29.4	1.91%	N/A
1st Qtr PY 2016	99.0%	**98.9%**	4.8 days	:29.1	1.94%	N/A
2nd Qtr PY 2016	98.6%	99.7%	3.5 days	:24.0	1.14%	N/A
3rd Qtr PY 2016	98.8%	**98.53%**	5.3 days	:29.0	1.96%	N/A
4th Qtr PY 2016	99.0%	99.52%	6.3 days	:29.5	1.98%	N/A
1st Qtr PY 2017	99.0%	99.23%	6.6 days	:29.8	1.93%	N/A
2nd Qtr PY 2017	99.6%	99.78%	4.3 days	:29.3	1.96%	N/A
3rd Qtr PY 2017	98.2%	**93.83%**	3.7 days	:29.8	1.97%	N/A
4th Qtr PY 2017	99.0%	99.66%	4.6 days	:29.3	1.98%	N/A
1st Qtr PY 2018	99.2%	99.83%	4.4 days	:26.0	1.61%	98.79%
2nd Qtr PY 2018	99.6%	99.9%	4.3 days	:12.8	1.12%	98.28%
3rd Qtr PY 2018	98.6%	99.7%	3.5 days	:28.5	1.97%	98.65%
4th Qtr PY 2018	99.4%	99.5%	4.2 days	:21.0	1.50%	97.65%
1st Qtr PY 2019	98.8%	**98.2%**	5.4 days	:21.0	1.49%	97.85%
2nd Qtr PY 2019	99.6%	99.9%	5.6 days	:21.0	1.40%	97.18%
3rd Qtr PY 2019	**98.4%**	**98.31%**	**5.8 days**	**:14.0**	**1.21%**	**95.89%**

Turnaround Time

Per the Service Performance Standards and Financial Guarantees Agreement, the turnaround time for payments of claims is measured in calendar days from the date HealthSCOPE receives the claim until the date of process. Ninety nine percent (99%) of complete claims adjudicated are to be processed within thirty (30) calendar days, excluding federal holidays, or a penalty of two percent (2.0%) of Quarterly Administration fees for each two and a half percent (2.5%) of non-compliance complete claims is to be applied. HCA had requested the report that reflects the measurement of this issue. This report reflected that 99.59% of "complete" claims were processed within 30 calendar days, in compliance with the performance guarantee. This report also displayed the total turnaround process time for all claims at 5.8 days.

Turnaround Time Measurements



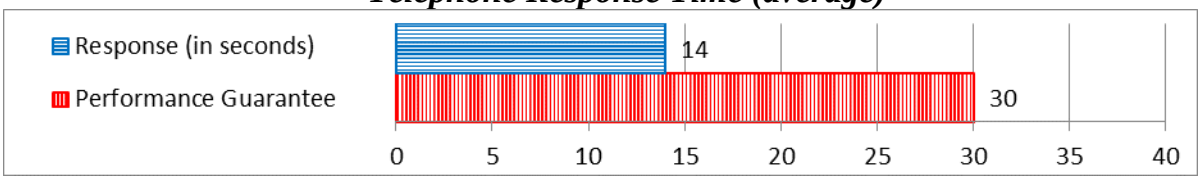
The turnaround time, measured only from the random selected claims, for Medical claims was 13.6 calendar days, Out Patient Hospital claims was 14.6 calendar days, In Patient Hospital claims was 11.8 calendar days and Dental claims was 1.9 calendar days.

During the audit period of 01 January 2019 to 31 March 2019, HealthSCOPE had received 1,030 PEBP e-mail inquiries for information via the internet. The average turnaround time for these inquiries was calculated at approximately 7.0 hours.

Customer Service Satisfaction

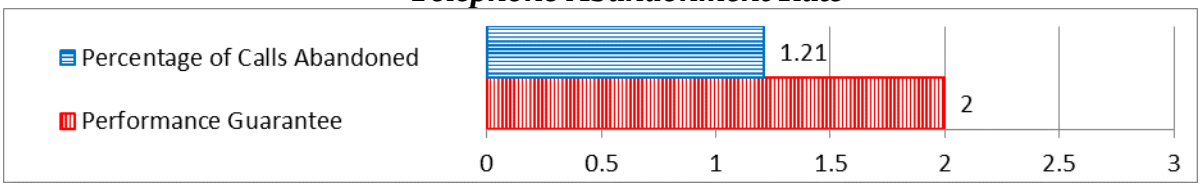
Per the Service Performance Standards and Financial Guarantees Agreement, the telephone response time reflects all calls must be answered within thirty (30) seconds or a penalty of one percent (1%) of Quarterly Administration fees for each second in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP third fiscal quarter Plan Year 2019, which revealed the average incoming answer speed to be 14.0 seconds (0:14.0). The telephone response time was 14 seconds for January 2019, 15 seconds for February 2019 and 13 seconds for March 2019.

Telephone Response Time (average)



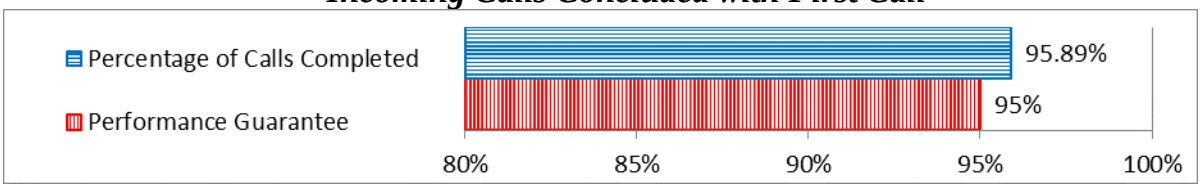
Per the Service Performance Standards and Financial Guarantees Agreement, the abandonment rate must be under two percent (2%) of total calls or a penalty of one percent (1%) of Quarterly Administration fees for each percentage point or fraction thereof in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP third fiscal quarter Plan Year 2019, which revealed the abandoned calls ratio to be 1.21%. The telephone abandonment rate was 1.11% for January 2019, 1.37% for February 2019 and 1.18% for March 2019.

Telephone Abandonment Rate



Per the Service Performance Standards and Financial Guarantees Agreement, ninety five percent (95%) of incoming PEBP member problems must be resolved to conclusion on the first call or a penalty of one percent (1%) of Quarterly Administration fees for non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP third fiscal quarter Plan Year 2019, which revealed that HealthSCOPE documented 95.89% of incoming calls were brought to completion on the first call.

Incoming Calls Concluded with First Call



HealthSCOPE has eighty plus (80+) Customer Service Reps (CSRs), of which, the majority are in the Little Rock office with an average of eight (8) years experience.

Health SCOPE currently has eighteen (18) CSRs dedicated to the PEBP plan.

HealthSCOPE stated that customer service hours of operation will be applied to PEBP direction for proper service levels.

Benefit data is supplied by electronic documentation so that the analyst may explain benefit information to clients, members and providers by HealthSCOPE.

HealthSCOPE stated that the customer service representatives will not have the ability to make system changes.

HealthSCOPE's telephone conversations are documented for future reference.

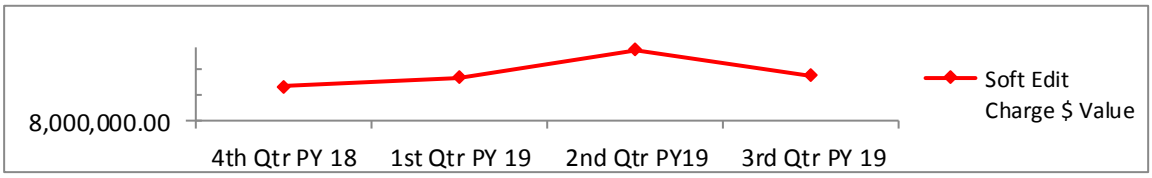
HealthSCOPE does have an audit process for Customer Service Representatives.

HealthSCOPE is able to monitor trends/errors found through Customer Service.

HealthSCOPE can conduct customer service satisfaction surveys to determine employee satisfaction of claims administration and service upon client request.

Soft Denied Claims

The audit identifies the volume of claims adjudicated and placed in a "soft denied" status. HCA recognizes and respects the need to place certain claims in a soft denied status such as claims that require additional information or special calculation of payment. It is important to include this data within this report to disclose the outstanding unpaid claims that could create an artificial debit/savings during the time that these claims were adjudicated. Note: The measurement of this data was provided as a "snapshot" report. The report reflected the "soft edit" amounts as they were reported on the specific day that the report was recorded. The report for the current claims placed in a "soft denied" status reflect a total of 5,476 claims representing $ 25,662,843.33.



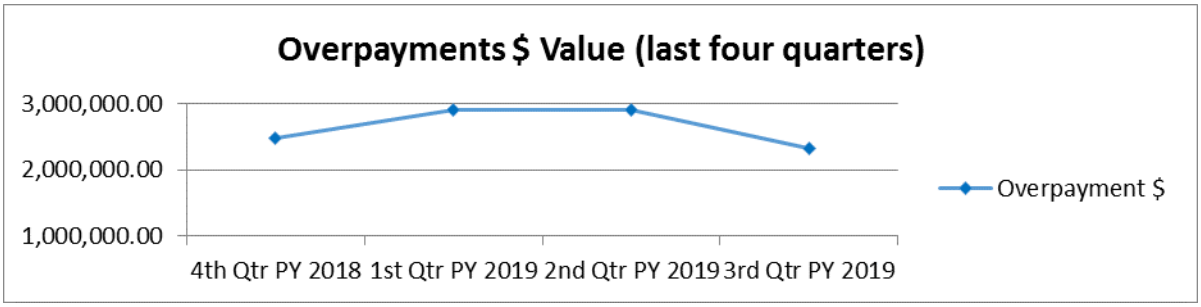
Audit Period	Total Number of Claims	Charge Amount Value of Soft Edits
1st Qtr PY 2012	2,607	$ 7,544,177.55
2nd Qtr PY 2012	4,068	$10,697,954.53
3rd Qtr PY 2012	1,536	$ 6,472,249.56
4th Qtr PY 2012	559	$ 2,205,318.16
1st Qtr PY 2013	1,053	$ 3,413,738.12
2nd Qtr PY 2013	1,107	$ 5,019,961.70
3rd Qtr PY 2013	1,023	$ 4,179,542.34
4th Qtr PY 2013	1,094	$ 3,049,481.74
1st Qtr PY 2014	1,389	$ 3,853,629.07
2nd Qtr PY 2014	1,157	$ 2,510,539.33
3rd Qtr PY 2014	1,621	$ 7,873,432.21
4th Qtr PY 2014	1.487	$ 4,665,197.77
1st Qtr PY 2015	1,404	$ 5,901,903.17
2nd Qtr PY 2015	1,668	$ 6,930,288.41
3rd Qtr PY 2015	2,897	$10,800,874.08
4th Qtr PY 2015	2,498	$10,685,255.24
1st Qtr PY 2016	3,071	$13,027,717.82
2nd Qtr PY 2016	2,543	$13,547,682.34
3rd Qtr PY 2016	2,871	$10,360,017.78
4th Qtr PY 2016	3,107	$15,262,995.27
1st Qtr PY 2017	2,580	$ 8,558,641.28
2nd Qtr PY 2017	3,876	$15,960,661.94
3rd Qtr PY 2017	3,696	$18,864,824.74
4th Qtr PY 2017	4,768	$20,217,736.28
1st Qtr PY 2018	3,926	$15,683,180.63
2nd Qtr PY 2018	4,073	$20,576,701.38
3rd Qtr PY 2018	4,144	$17,375,843.66
4th Qtr PY 2018	4,544	$21,591,987.11
1st Qtr PY 2019	4,624	$24,992,938.88
2nd Qtr PY 2019	5,558	$36,168,714.98
3rd Qtr PY 2019	**5,476**	**$25,662,843.33**

Overpayments

HCA requested an overpayment report that reflects the identified current outstanding overpayments incurred since the beginning of the contract period with HealthSCOPE. This report reflected a current total potential recovery value of $2,322,865.51 (a decrease of $575,663.88). Detailed information regarding outstanding overpayments can be reviewed in a separate Supplemental Report, which for confidentiality purposes, is not included in this report but is made available to PEBP staff should they request it.

HSB's policy is to keep all identified overpayments active for potential recoupment(s The breakout of overpayments identified by the year paid are as follows:

Period	Due/Potential Recovery
- Fiscal Year 2012	$ 126,872.76
- Fiscal Year 2013	$ 192,584.73
- Fiscal Year 2014	$ 91,077.33
- Fiscal Year 2015	$ 210,833.02
- Fiscal Year 2016	$ 230,377.03
- Fiscal Year 2017	$ 213,224.61
- Fiscal Year 2018	$ 563,101.17
- Fiscal Year 2019	$ 694,794.86
TOTAL	$2,322,865.51



Of the 2,402 most current (Plan Year 2019) identified outstanding overpayments (HSB only), 76% were found to be caused by external sources that are not a cause of the HealthSCOPE adjudication processes. Breakout of the HealthSCOPE's most current (PY19) overpayments (by claim count) are listed by reason as follows:

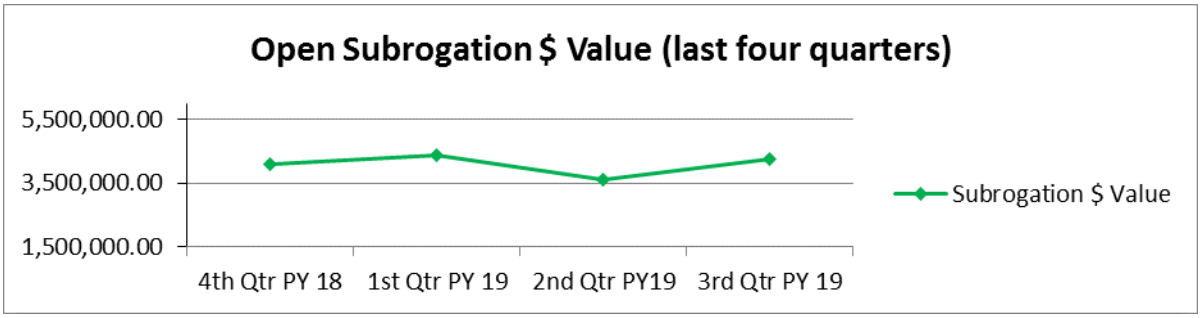
26.60%	SHO Pricing Correction
12.17%	Provider caused, rebilled, charges billed in error, corrected EOB
11.42%	Previous Information Received
10.71%	No COB on file
10.59%	Incorrect Benefit Applied
8.80%	Corrected HTH Network Pricing
7.25%	Retro termination
5.92%	Incorrect Rate Applied
1.50%	Duplicate
0.66%	Service not covered
0.62%	Pharmacy claim deductible/Co-Insurance error
0.50%	COB incorrectly calculated or not applied
0.41%	Paid in excess of max limit
0.37%	Pre-Certification
0.33%	Adjusted after medical review
0.29%	Processed under the incorrect provider
0.25%	Industrial and/or possible Workers Compensation claim
0.25%	Paid NON PPO as PPO
0.25%	Stop Payment
0.20%	Incorrect assignment applied
0.20%	Eligibility
0.17%	Benefit Clarification
0.08%	Processed under incorrect patient
0.08%	Paid PPO provider as NON PPO
0.08%	Asst Surgeon paid as Surgeon
0.04%	Subrogation error
0.04%	Entry Error
0.04%	Aetna Correction
0.04%	Appeal
0.04%	Denied in Error

Subrogation

HCA requested a subrogation report that can be reviewed in a separate Supplemental Report, which for confidentiality purposes is not included in this report. It is made available to PEBP staff should they request it.

This report reflects open subrogation claims representing a current potential recovery amount of $4,248,120.91; an increase of $638,815.75 from the previous quarter.

Reports received from HealthSCOPE reflect that subrogation recoveries for the audited period was $569,919.62. After contingency fees were paid, PEBP received $416,346.87.



HealthSCOPE system will apply a pursue and pay subrogation policy as directed by PEBP. Per HealthSCOPE, subrogation is determined and pursued on all claims where the total amount paid equals to or exceeds $1000 (one thousand).

HealthSCOPE does identify possible subrogation cases internally. HealthSCOPE utilizes a third party vendor for recovery of monies. Vendors are paid a contingency of which the administrator receives a portion of and disclosed within RFP 1983 for Third Party Claims Administration.

HealthSCOPE does not conduct auditing of outstanding subrogation cases sent to their vendors, but sends any cases not picked up by the main vendor to another vendor for review.

HealthSCOPE depends on the external vendors to conduct the appropriate International Classification of Diseases (ICD) sweep checks for subrogation detections. HealthSCOPE is currently utilizing the new ICD-10 conversions and the coding has been completed within their system.

Per HealthSCOPE, claims related to Worker's Compensation are denied.

Recoupment and payments for subrogation claims are assigned as directed by PEBP.

High Dollar Claimants

Per the request of PEBP staff, HCA has requested a report to identify the number of active, retiree or COBRA elected participants or dependents who have obtained a plan paid level of $750,000.00 or greater.

This report reflected thirty-six (36) active members and twenty-seven (27) dependents for a total of 63 active participants, who have obtained this level of plan payment participation representing an accrued dollar paid amount of $84,132,919.45.

Personnel

The audit included a review of the HealthSCOPE personnel dedicated or assigned to PEBP. The current Organization Chart for individuals assigned to the PEBP plan, is, with changes, as follows:

- State of Nevada Manager;
- Vice President – Quality Assurance;
- Sr. Vice President Operations Customer Care;
- Executive Account Manager;
- Client Relations Manager;
- Financial Operations Director;
- Provider Maintenance Specialist;
- Financial Analysts, 3 individuals;
- Funding Supervisor;
- Claims Administration Manager;
- Claims Administration Supervisor;
- Claims Analysts, **CHANGE**, 2 individuals added for a total of 14 individuals;
- Eligibility Director;
- Eligibility Supervisor;
- Customer Service Vice President;
- Customer Service Director;
- Customer Service Representatives, **CHANGE**, 1 individual added and 1 removed for a total of 18 individuals;
- Scanning Services Manager;
- Recoveries Manager;
- Recoveries Specialists, 2 individuals;
- Vice President Data Services;
- Senior Data Analyst;
- Chief Information Officer;
- Data Architect
- Computer Domain Hosting (CDH) Services Manager;
- Sr. Vice President-Legal and Compliance;
- COBRA Service Manager;
- Customer Care Supervisor;
- Customer Care Representatives, 3 individuals.

HealthSCOPE POLICY/PROCEDURES/SYSTEM CAPABILITIES

This section details the HealthSCOPE adjudication system capabilities and operations as they pertain to the PEBP Health Plan. These operations typically do not change on a regular basis and remain redundant within subsequent audit reports, thereby, are only displayed within the first quarterly audit report for the fiscal year. The quarterly audit includes the review of the following operations, however, if any changes or defects are identified, they will be reported immediately within the audited period report:

- HealthSCOPE Policy/Procedures
- Eligibility
- Deductibles, Out-of-Pocket and Benefit Maximums
- Unbundling/Rebundling
- Concurrent Care
- Code Creeping
- Procedure, Diagnosis and Place of Service
- Experimental and Cosmetic Procedures
- Medical Necessity/Potential Abuse Guidelines and Procedures
- Patterns of Care and Treatment for Physicians
- Mandatory Outpatient/Inpatient Procedures
- Duplicate Claim Edits
- Adjusted Claims
- Hospital and Other Discounts
- Hospital Bills (UB-92) and Audits
- Filing Limitations
- Unprocessed Claims Procedures
- Reasonable/Customary and Maximum Allowances
- Membership Procedures
- COBRA Administration
- Provider Credentialing
- Coordination of Benefits
- Medicare
- Controlling Possible Fraudulent Claims and Security Access
- Quality Control and Internal Audit
- Internet Capabilities
- Communication between Utilization Review (UR) and Claims Department
- Claim Repricing Capabilities
- Banking and Cash Flow
- Reporting Capabilities
- General System
- Security

HCA CLAIM AUDIT PROCEDURES

HCA selects a valid random sampling of claims from the client's current detailed claims listings. The third party administrator is advised of the audit and requested to provide either limited system access or paper reproduction of the entire file associated with each random claim.

Each random claim and file is reviewed comparing eligibility and benefits to information provided by the client. Third party administrator personnel are questioned regarding any discrepancies. Entire files are reviewed to assure the client that deductibles, out-of-pockets benefit maximums and related claims are processed correctly. This allows HCA to verify all details of the client's benefit plan.

Audit statistics involve only those claims chosen in the random selection. If a randomly selected claim HealthSCOPE been recalculated or corrected prior to the release of the random selection for the audit, an error was not charged for the original miscalculation. HCA will, at its opinion, comment on any claim in the random claim history to illustrate situations it feels the client should be aware of or specific areas requiring definition.

A payment error is charged when an error identified in claim processing results in an under/ overpayment or a check being paid to the wrong party. Assignment errors are considered payment errors since the plan could be liable for payment to the correct party.

In situations where there is disagreement between HCA and the third party administrator as to what constitutes an error, both sides are presented in the report. Final determination of error rests with the client.

AUDIT RESULTS

Listed below are the errors or issues of discussion found by this audit while processing the claims for PEBP.

Ref. No. 005 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
A7030 chg 171.50
A7035 38.50
Originally paid claim at 100% with no discount on 11/30/18
Adjusted claim on 1/5/19 to allow: A7030 = 108.28
A7035 = 22.81
Was original claim repriced by HTH with no discount and reflected as Non-PPO?
HSB response: Yes. Original claim returned by HTH as non-par.

Ref. No. 032 Medical HSB claim no.

Underpayment - $75.00

Audited claim is for physician's charges:

DOS 11/26 77427 chg 571.00 allow 249.15

11/21-11/30 77014.26 x 5 days chg 199.00 ea allow 59.18 ea

$75.00 copay applied

Claim xxxxxx for hospital services is for 77336 & 77386. The $75.00 copayment was applied to each day of radiation treatment.

Should the $75.00 copay have been applied to the hospital claim or the audited claim for the same date of service with both for radiation treatment?

HSB response: No copay should only be applied once. Agree audited claim underpaid $75.00.

Ref. No. 082 Medical HSB claim no.

Underpayment - $1,166.04

S9480 chg 1000 ea allow 166.87 ea pd 83.49 ea

File reflects 45 billings from this provider originating on 2/26/18 through 4/4/19. All had significant discounting applied except claim xxxxxx DOS 7/3/18-7/9/18, S9480 x 4 charged 4000.00 allowed 3400.00 paid 1700.00

EOB states discount from same three Rivers Provider Network

Should claim xxxxxx have been paid at $333.96 versus $1700.00?

HSB response: Per Zelis (audited) claim xxxxx priced incorrectly – correct allowed $3400.00 & attached. Claim xxxxxx priced correctly.

HCA Note: Per attached both claims were priced by network at $3400.00 for four (4) dates of service.

Ref. No. 105 Medical HSB claim no.

Overpayment - $25.00

99214	chg 370.00	allow 241.00	pd 241.00	excess 129.00
96127-59	50.00	50.00	50.00	

Shouldn't $25 OV copay have been applied?

HSB response: Agree. Claim should have taken $25.00 copay.

Ref. No. 114 Outpatient Hospital HSB claim no.
Underpayment - $30.00
REV 305, CPT 85610 chg 58.00 allow 3.39 pd 3.39
761, 99212 209.00 93.84 93.84
Claim adjusted on 2/20/19 under xxxxxx to now pay as:
REV 305 allow 3.39 pd 3.39
761 93.84 copay 75.00 18.84
Appears to be taking "All Other (Non-Specialty) Imaging and Diagnostic Testing (including x-rays and ultrasounds) services provided in hospital outpatient setting" copay.
Charges are for lab (which has a $0 copay) and hospital outpatient treatment room. Please explain why claim was adjusted to take $75 copay as it appears audited claim was paid correctly.
(Note: Multiple claims in history for these services from this provider, some taking $75 copay, some taking $45 copay)
HSB response: $45.00 copay is correct as facility is billing 99212-OV.
UP $30.00 on Txxxxxx.

Ref. No. 149 Outpatient Hospital HSB claim no.
Overpayment - $75.00
76536.TC chg 818.00 allow 801.64 pd 801.64
Shouldn't the $75.00 copay have been applied?
HSB response: Agree. Claim should have taken $75.00 copay. OP $75.00.

Ref. No. 219 Medical HSB claim no.
Overpayment - $114.65
93000 chg 80.00 allow 32.37 pd 32.37
99204.25 340.00 82.28 82.28
Please explain why this claim paid at 100%. (OOP not met & related facility claim applied to deductible)
HSB response: Analyst error. Wrong category chosen. OP $114.65.

Ref. No. 220 Medical HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
A6550 chg 89.70 allow/pd 31.47
A7000 153.00 7.30
This claim is for accessories for E2402 & was received 1/29/19
Claim xxxxxx is same DOS, same provider for E2402 (Neg press wound therapy electrical pump). Claim denied as not authorized. Charge 5278.69 and was received on 1/29/19.
Since pump denied as not authorized, shouldn't audited claim for pump accessories also be denied?
HSB response: Audited claim is for medical supplies and paid w/o auth because billed charges did not exceed $1000.00. No error.
HCA note: it is the auditor's opinion that if the pump was denied, all supporting materials of the pump should have also been denied.

Ref. No. 223 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
REV 730, 93005.59 chg 443.79 allow/pd 332.84
Audited claim adjudicated with HTH network discount
Claim xxxxxx same provider & TIN, same DOS is being sent to Aetna for repricing. Charge 7756.63.
Shouldn't audited claim have also been sent to Aetna for repricing discounts?
HSB response: HTH priced both claims. Due to billed charges on biased Txxxxxx, claim sent to Aetna for pricing comparison. No error.

Ref. No. 229 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim is from provider Quest Labs. Numerous random claims are for Quest processed in late January & early February 2019. All were delayed for payment for SHO pricing correction. Was there a issue w/SHO contract pricing during this time? (Note: HCA ref nos. 225 – 231)
HSB response: Quest Diagnostics is dual contracted. Programming changed to not allow as SHO in error. This issue was corrected & reports ran to rework impacted claims. All adjustments completed prior to audit. No error.

Ref. No. 232 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
99396 chg 259.00 allow/pd 118.00
Claim adjusted under xxxxxx on 3/25/19 to now pay as: allow/pd 55.68
Per Trns Msg "corrected fees"
Previous claim in 2017 claim xxxxxx DOS 9/2/17 same provider/service paid 55.68
Why was audited claim priced & paid at 118.00?
HSB response: We received an ACT form for this provider in Oct 2018. At that time the fee schedule was changed to manual in error. This caused the old pricing for provider to be used to price claim. This was corrected & reports ran to correct claims. These were adjusted prior to audit. No error.

Ref. No. 242 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Paid as: 11102 chg 203.84 allow 0.00 pd 0.00
99203 222.36 125.38 ded 125.38 pd 0.00
Claim adjusted on 3/1/19 under claim xxxxxx to now pay as:
11102 allow 113.47 ded 113.47
99203 125.38 125.38
Per Trns Msg: corrected HTH pricing received
Appears HTH repriced 11102 originally at $0?
HSB response: Yes HTH originally allowed $0. Corrected pricing received from HTH on report dated 2-28-19 to allow $113.47. See Txxxxxx.
No error.

Ref. No. 260 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Originally paid 1/4/19 under xxxxxx as:
96402 chg 95.00 allow 41.22 copay 41.22 pd 0.00
J1950 3500.00 1193.67 33.78 1159.89
75.00
Audited is adjusted claim to pay additional 101.34 – now pd as:
96402 allow 41.22 copay 41.22 pd 0.00
J1950 1295.01 33.78 1261.23
Appears HTH original repricing incorrect?
HSB response: HTH original pricing was incorrect. They corrected pricing on 1/7/19. No error.

Ref. No. 307 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider – Centennial Hills (Valley Health System)
Originally paid 2/5/18 under claim xxxxxx taking 65% discount:
ER allow 695.80 paid 556.64
Audited claim is adjustment on 2/19/19 to now pay with 66% discount:
ER allow 675.92 paid 540.74
When was HSB notified of contract change on these services?
HSB response: Final clarification was received 10/18/18.

Ref. No. 328 Outpatient Hospital HSB claim no.

Overpayment - $75.00
REV 920 CPT 93971 – RT Duplex scan of extremity veins unilateral or unlimited
Paid as: allow/paid 570.56
Appears to be Non-Specialty Imaging & Diagnostic Testing done in hospital outpatient setting. Shouldn't $75 copay have been applied?
HSB response: Agree. $75.00 overpaid.

Ref. No. 414 Medical HSB claim no.

Overpayment - $3,057.41
Claim originally paid 10/15/18 under xxxxxx paying as:
J1569 allow 3821.76 paid 3057.41
(Suspense Memo #3 shows AC = 3683.64)
Audited claim is adjustment to pay as:
J1569 allow 3683.25 at 100%
1) Since we had already paid 3057.41, shouldn't we have only paid an additional 625.84 on audited?
2) Why did we not used the allowed of 3683.64 on original processing?
HSB response: 1) Yes. 52) We should have used 3683.64 when claim originally processed, not 3821.76. Analyst error when claim for DOS 8/15/18 was reconsidered upon receipt of provider inquiry.

Ref. No. 495 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.

97010	chg 25.00	allow 11.12
97110	100.00	44.44
97140	100.00	44.44
	225.00	100.00 x 80% = 80.00 – prev pd 71.10 = 8.90

Original claim paid 71.10 on 11/12/18. Audited claim is adjustment to allow global fee of $100.00 on 3/27/19.
HSB response: Claim adjusted to allow 100.00 global fee making additional payment of 8.91. No error.

Ref. No. 505 Inpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider – Sunrise Hospital
This inpatient hospital claim repriced as:
DRG 229 (day 1-6) = 52,733.00
Add'l days 12 x 2965 = 35,580.00
Rev 278, 8217 x 40% = 3286.80
Rev 390, 4893 x 20% = 978.60
Rev 636, 23,459 x 40% = 9383.60
101,962.00 – 500 copay = 101,462.00 pd 2/1/19
Contract states: Pediatric rates when DRG 229 with revenue code 203 are present on bill/UB: Other Cardiothoracic (MS-DRG 229) is 37% of billed charges. Should allowable have been:

Carve outs: Rev 278, 8217.00 x 40% = 3286.80
390, 4893.00 x 20% = 978.60
636, 23459.00 x 40% = 9383.60
36,569.00
Balance 1,280,129.00 x 37% = 473,647.73
487,296.73
Should allowable have been 487,296.73 versus 101,962.00?
(Note: MSI repriced 2/1/19)
HSB response: Pediatric Cardiology rates were not applied to pricing. We had received call on 3/26/19 prior to audit and were working with HTH on getting corrected pricing to correct the claim. Corrected pricing was received on 4/4/19, validated and claim reprocessed on 4/17/19.

27 Corporate Hill
Little Rock, AR 72205

May 10, 2019

Public Employees' Benefits Program Board
State of Nevada
901 Stewart Street, Suite 1001
Carson City, NV 89701

Subject: Audit Results January 1, 2019 – March 31, 2019

Dear Public Employees' Benefits Program (PEBP) Board:

HealthSCOPE Benefits appreciates the opportunity to respond to the audit performed by Health Claim Auditors for the third quarter of Plan Year 2019. The audit included 500 claims with paid amounts totaling $273,007.02

HealthSCOPE Benefits is extremely disappointed to have missed the financial accuracy percentage for this audit period. We take the quality of our work very seriously and strive for perfection.

We continue to review quality improvement opportunities within our organization and our vendor partners. Based on our review, we have implemented the following quality control measures:

Item (1)
HealthSCOPE Benefits will conduct training classes and continuing education courses for the Claims staff to continue to stress quality goals and review of provider billing practices.

Item (2)
HealthSCOPE Benefits has requested an internal audit on the EPO Premier Plan copay structure and we will make the appropriate benefit programming changes based on the outcome of our Quality Assurance audit.

We are very pleased with cost containment measures we are able to provide on the PEBP account. We saved PEBP an additional $1.6M through non-network negotiations, subrogation, clinical edits and transplant savings in the third quarter of Plan Year 2019.

We appreciate the quarterly audit process and the interaction between Health Claims Auditors, PEBP, and HealthSCOPE Benefits as it provides for continuous improvement in our service.

Sincerely,

Mary Catherine Person
President & Co-CEO

6.

6. Discussion and update on PEBP's Open Enrollment results for Plan Year 2020. (Laura Rich, Operations Officer)
(Information/Discussion)

STEVE SISOLAK
Governor

Deonne E. Contine
Board Chair

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Expires 04/01/2021

DAMON HAYCOCK
Executive Officer

AGENDA ITEM

☐ Action Item

☒ Information Only

Date: July 25, 2019

Item Number: VI

Title: Open Enrollment Update

REPORT

OPEN ENROLLMENT

PEBP's Open Enrollment period was available at a later date this year to account for Legislative approval of Plan Year 2020 rates. Traditionally, PEBP's Open Enrollment is May 1 - 31; however this year it occurred from May 21 - June 7. This delayed open enrollment created some challenges on staff and the program. In addition to a delayed open enrollment, PEBP implemented an eligibility and enrollment system overhaul, as well as the introduction of many new voluntary products.

These circumstances created an extra lift on PEBP staff during an already busy time. PEBP had to ensure that significant noticing and communications were developed and circulated to make sure members were well informed of the latest changes. All the benefit guides, Master Plan Documents, open enrollment presentations and other reference documents had to be edited and republished. All website information had to be updated as well. Our member services unit fielded calls from members with inquiries about rate availability while accounting staff rushed to test the calculations of rates in the member enrollment portal to ensure correct premiums and HSA/HRA amounts were being displayed.

During a typical open enrollment year, approximately 2,500 open enrollment elections are processed by the eligibility unit. This number almost doubled to 4,900 this year. As illustrated in the table below, the migration between plans from PY19 to PY20 was not significant, so the increase in volume is largely due members enrolling into one or more of the voluntary products rather than changing medical plans.

Enrollment by Plan		
	June 30, 2019	July 1, 2020
CDHP	23,557	23,150
HMO	4,652	4,788
EPO	3,846	3,915
Medicare Exchange	12,539	12,636

The majority of the new voluntary products that rolled out in May are products which can only be enrolled in or changed during open enrollment. The table below highlights the enrollment numbers for the various products launched at the start of open enrollment. The remaining products (launched on July 1) are products that can be purchased or discontinued at any time during the plan year. Given that we are only 3 weeks into the launch of these products, no enrollment numbers are available yet.

Voluntary Product Enrollments		
	Existing Policies	**New Policies**
AFLAC Accident	N/A	485
AFLAC Hospital Indemnity	N/A	424
AFLAC Critical Illness	N/A	419
The Standard Voluntary Life	5,495	2,025
VSP	N/A	2,252
ID Theft	N/A	273
Legal Plan	N/A	389
TOTAL	**11,762**	

PEBP was successful in transitioning existing policies from the current vendors (The Standard and Liberty Mutual) on to the portal so that members would not experience a gap in coverage, however Unum Long Term Care and The Standard Short-Term Disability could not be offered on the portal due to some technical and data limitations. Employees do continue to have the option of enrolling in these products using the existing paper enrollment which can be accessed through the portal or through the vendor website.

CALL CENTER STATISTICS

Two years ago, PEBP made the cost saving decision to move away from using an overflow call center during Open Enrollment and instead opted to bring it in-house. This required a commitment from all staff to be available during the April through June time frame to answer incoming member inquiries in addition to their normal duties. Not only did this decision save PEBP approximately $80,000/year, it also provided our members with better, more reliable and accurate information about our plans.

PEBP call center statistics have consistently exceeded the performance measures that are imposed on our vendors. However, due to the many unforeseen challenges and some staffing shortages, the PEBP abandonment rate during this open enrollment increased slightly above what is considered ideal. Call volume did increase significantly and although email volume appears to have dropped slightly, that statistic is to some extent misleading. In the past, members submitted their supported documents through email. These emails did not require research or a response. Document submission is now a function that is offered in the new portal. Members can upload their documents which are automatically tied to their account. The email volume shown in the table below represents inquiries that require responses versus large volumes of emails with attachments that previously did not require a response.

	PLAN YEAR 18				PLAN YEAR 19			
	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018	Jul-Sep 2018	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019
PEBP Abandoned Calls	113	106	273	339	157	108	182	924
PEBP Answered Calls	10,385	8,643	11,001	14,168	11,645	8,286	9,428	16,449
PEBP Average # of Calls Answered Per Day	168	139	177	229	188	134	152	265
PEBP Abandonment Rate	1.09%	1.23%	2.48%	2.39%	1.35%	1.30%	1.93%	5.62%
PEBP Average Call Duration (minutes)	0:04:09	0:04:14	0:04:32	0:04:45	0:05:18	0:05:16	0:04:55	0:05:01
PEBP Average Speed to Answer (seconds)	0:00:15	0:00:18	0:00:24	0:00:26	0:00:25	0:00:22	0:00:32	0:01:32
PEBP Total Walk-ins	293	388	347	399	347	378	325	103
PEBPAverage # of Walk-ins Per Day	4.7	6.3	5.6	6.4	5.6	6.1	5.2	1.7
PEBP Total Emails	3202	4072	4791	6556	5397	4526	5013	4727

NEW ENROLLMENT TOOL & VOLUNTARY BENEFITS PLATFORM

In July 2018, Morneau Shepell presented to the Board a member enrollment technology upgrade solution. To align with PEBP's goal of improving the member experience and lowering costs, the intent of the upgrade was to provide an enhanced enrollment tool as well as an integrated voluntary benefits platform at no cost to PEBP. Morneau Shepell would recoup their $1.25 million investment by commissions gained through the sale of voluntary products purchased by PEBP members on the integrated platform. In September 2018, PEBP presented, and the Board approved, an amendment to the Morneau Shepell contract that clearly lined out the requirements of the enhanced enrollment system and voluntary benefits platform, as well as a two-year extension of the contract.

The roll out of the new member portal has presented some challenges, both on the member facing side and on the administrative side. The goal of the new portal was to deliver an improved member experience, which would include new tools that would allow members to more easily navigate through their medical and voluntary benefit selections. Furthermore, technology improvements in the new system were projected to alleviate many of the manual efforts required of PEBP staff by automating much of the enrollment approval process on the administrative side. Although the new member portal has presented members with several new tools and a much improved user interface, the delivered product as it stands today does not meet the vision of what PEBP expected. Morneau Shepell has acknowledged that they have not achieved the desired expectations and they continue to work diligently correcting all identified defects and implementing continuous system improvements. Recognizing their responsibility as a long-time vendor and partner, Morneau has taken full accountability and in concept, agreed to the following:

- **Provide PEBP with a formal Process Improvement Plan –** Morneau Shepell will provide a monthly report outlining measurable short-term, mid-term and long-term goals as well a detailed breakdown of action items and milestones. Data from this plan will be used to develop Board reports every other month.
- **Reduce the PEPM fees** - The goal was for Morneau Shepell to eventually pass on savings by providing PEBP with lowered PEPM rates once Morneau Shepell recovered their initial investment. PEBP will receive lowered fees earlier to make up for an unsuccessful launch last May.
- **Provide onsite staff for the duration of improvements** – This provides PEBP with an immediate technical resource and liaison. This resource will assist PEBP staff with system and process improvement and hands on technical support. This resource should be onsite full-time no later than October 1, 2019.

In mid-August, PEBP will be meeting with Morneau Shepell leadership to collectively settle on the specifics of each of the items above. The initial process improvement plan will be presented by Morneau Shepell at the September 26th board meeting and a status update will be expected at every subsequent board meeting through July 2020.

Morneau Shepell has been a PEBP partner since 2006 and similarly to the steps PEBP has taken with other vendors, PEBP is providing Morneau Shepell the opportunity to make the improvements necessary to achieve an acceptable level of success. The expectation is that both the member facing and administrative portals, as well as the in-progress data interfaces will be fully functional by Plan Year 2021 Open Enrollment. PEBP will provide an overall assessment of the required improvements to the Board in July of 2020. If Morneau Shepell has still not achieved agreed upon success, PEBP will provide the Board a strategy to decommission the current system and implement a replacement in the next biennium.

7.

7. Discussion and possible action to approve a retroactive amendment with HealthSCOPE Benefits for lowered cost out-of-state medical network services available to members on the Consumer Driven Health Plan (CDHP) and Exclusive Provider Options (EPO) plan. (Cari Eaton, Chief Financial Officer) (**For Possible Action**)

STEVE SISOLAK
Governor

Deonne Contine
Board Chair

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DAMON HAYCOCK
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: July 25, 2019

Item Number: VII

Title: Contract Amendment Report – HealthScope Benefits

SUMMARY

This report requests the Board authorize staff to complete a contract amendment between PEBP and HealthSCOPE Benefits to provide a medical Preferred Provider Organization (PPO) network for participants who reside outside of Nevada and for those who live in Nevada and choose to seek medical services out of state at a reduced rate.

REPORT

HEALTHSCOPE BENEFITS PPO NETWORK

PEBP entered into a 4-year contract with HealthSCOPE Benefits for national PPO Network services effective July 1, 2012 resulting from RFP # 1963. This contract has been extended through June 30, 2020. PEBP staff has negotiated a reduction to out-of-state PPO Network fees from $16.48 PEPM to $13.49 PEPM in FY20 with a potential 4% increase each year of the contract. The reduction of fees will be retroactively effective July 1, 2019 and result in a projected savings to PEBP of $85,000.

Fee Type	Pre-Amendment Projected Cost	Post-Amendment Projected Cost	Total Projected Savings
Out-of-State PPO Network Fees – FY 20	$184,312	$150,872	$33,440
Out-of-State PPO Network Fees – FY 21	$186,772	$158,326	$28,447
Out-of-State PPO Network Fees – FY 22	$189,420	$166,317	$23,103
TOTAL	**$560,505**	**$475,515**	**$84,989**

RECOMMENDATION

PEBP recommends the Board authorize staff to complete a contract amendment between PEBP and HealthSCOPE Benefits for National PPO Network services in contract # 13330 to reduce fees through the term of the contract.

8.

8. Discussion, update and possible action on the 80th Legislative Session with Board approval to opt-in to emergency service reimbursement provisions of AB 469 and update plan benefits for CDHP and EPO members on January 1, 2020 in accordance with AB 472 for the addition of gestation carrier maternity services. (Damon Haycock, Executive Officer) (**For Possible Action**)

STEVE SISOLAK
Governor

Deonne E. Contine
Board Chair

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DAMON HAYCOCK
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: July 25, 2019

Item Number: VIII

Title: 2019 (80th) Legislative Session Summary

Summary

This report provides

Report

Bill Number & Description	Bill Status
AB170 (BDR 57-278) Revises provisions relating to health insurance coverage. Requires an insurer to provide certain information relating to accessing health care services to the Office of Consumer Health Assistance; requiring the Governor's Consumer Health Advocate to submit a report of such information to the Legislature; requiring an insurer to offer a health benefit plan regardless of health status. PEBP currently provides this health benefit plan offering regardless of health status. **Effective Date:** January 1, 2020.	Approved by the Governor. Chapter 61.
AB254 (BDR 40-20) Revises provisions relating to sickle cell anemia. Requires a health insurer to include coverage for certain prescription drugs and services for the treatment of sickle cell disease and its variants in its policies. PEBP currently provides this coverage. **Effective Date:** October 1, 2019.	Approved by the Governor. Chapter 349.

Bill Number & Description	Bill Status
AB469 (BDR 40-704) Revises provisions governing billing for certain medically necessary emergency services. Prohibits an out-of-network provider from charging a person covered by a policy of health insurance an amount for medically necessary services that exceeds the copayment, coinsurance or deductible required. Any entity or organization as defined in NRS 287.04052 and any other local government agency which provides a system of health insurance benefits may elect for the provisions of this bill. **Effective Date:** January 1, 2020.	Approved by the Governor. Chapter 62.
AB472 (BDR 57-812) Revises provisions relating to insurance coverage of maternity care. An insurer that offers or issues a policy of health insurance that includes coverage for maternity care shall not deny, limit or seek reimbursement for maternity care because the insured is acting as a gestational carrier. PEBP will align the plans and update the Master Plan Documents to incorporate this regulation change. **Effective Date:** January 1, 2020.	Approved by the Governor. Chapter 188.
SB135 (BDR 23-650) Provides for collective bargaining by state employees. Section 24(2)(a) collective bargaining and supplemental bargaining entail a mutual obligation of the Executive Department and an exclusive representative to meet and bargain in good faith with respect to the subjects of mandatory bargaining in subsection 2 of NRS 288.150, except paragraph (f) of that subsection which is insurance benefits. **Effective Date:** Upon passage and approval. (June 12, 2019)	Approved by the Governor. Chapter 590.

Bill Number & Description	Bill Status
SB302 (BDR 52-547) Revises provisions relating to personal information collected by governmental agencies. If a governmental agency maintains records which contain personal information of a resident of this State, the agency shall comply with the current version of CIS Controls as published by the Center for Internet Security, Inc. or its successor organization, or corresponding standards adopted by the National Institute of Standards and Technology of the United State Department of Commerce. PEBP currently has security controls in place. **Effective Date:** January 1, 2021.	Approved by the Governor. Chapter 412.
SB378 (BDR 18-574) Revises provisions relating to prescription drugs. Requires the Department of Health and Human Services to develop a list of preferred prescription drugs to be used for the Medicaid program. Per section 28.5 PEBP may use the list of preferred prescription drugs developed by HHS as its formulary and obtain prescription drugs through the purchasing agreements negotiated by HHS. **Effective Date:** January 1, 2020.	Approved by the Governor. Chapter 616
SB524 (BDR S-1249) Makes a supplemental appropriation to the Non-State Retiree Rate Mitigation Account for a projected shortfall related to payment of supplemental subsidies for coverage of non-state, non-Medicare retirees under the Public Employees' Benefits Program. Allocates the sum of $127,819 to PEBP for a projected shortfall related to payment of supplemental subsidies. **Effective Date:** Upon passage and approval. (June 1, 2019)	Approved by the Governor. Chapter 302.

Bill Number & Description	Bill Status
SB550 (BDR S-1268) Establishes for the 2019-2021 biennium the subsidies to be paid to the Public Employees' Benefits Program for insurance for certain active and retired public officers and employees. The State's share of the cost of premiums or contributions for group insurance for each active state officer or employee who elects to participate in PEBP is: For the fiscal year 2019-2020, $760.79 per month and for fiscal year 2020-2021, $783.30 per month. For retired members participating in PEBP: For the fiscal year 2019-2020, $551.77 per month, and for fiscal year 2020-2021, $478.15 per month. The share of cost for those retired before January 1, 1994 is $195.00 per month. For retirees after January 1, 1994 for fiscal year 2019-2020 and 2020-2021 it is $13.00 per month per year or service up to 20 years excluding service purchased, up to a maximum of $260.00 per month. **Effective Date:** July 1, 2019.	Approved by the Governor. Chapter 523.
SCR10 (BDR R-1284) Directs the Legislative Commission to study the feasibility, viability and design of a public healthcare insurance plan that may be offered to all residents of this State. To complete the study, the Legislative Commission may enter into a contract with one or more consultants to conduct an actuarial or other appropriate analysis to determine the feasibility of offering a public option health insurance plan that is established to allow any resident of this State to participate in the Public Employees' Benefits Program and the effect that such an option would have on individual and small group health insurance markets. **Effective Date:** Upon passage and approval. (June 6, 2019.)	Enrolled and delivered to Secretary of State. File No. 45.

Recommendation

PEBP recommends participating in the provisions of AB469 and align maternity benefits with AB472.

9.

9. Election of Board Vice-Chair pursuant to Nevada Administrative Code (NAC) 287.172. Eligible candidates are Don Bailey, Sr., Linda Fox, Leah Lamborn, John Packham, Mandy Hagler, Tom Verducci, and Christine Zack. (Deonne Contine, Board Chair) (**For Possible Action**)

10.

10. Public Comment

11.

11. Adjournment